

Hawaii

UNIFORM APPLICATION

FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
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Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State DUNS Number

Number 809935679

Expiration Date 12/16/2017

I. State Agency to be the Grantee for the Block Grant

Agency Name Department of Health

Organizational Unit Behavioral Health Administration

Mailing Address P.O. Box 3378

City Honolulu

Zip Code 96801

II. Contact Person for the Grantee of the Block Grant

First Name Lynn

Last Name Fallin

Agency Name Department of Health, Behavioral Health Administrator

Mailing Address P.O. Box 3378

City Honolulu

Zip Code 96801-3378

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Email Address lynn.fallin@doh.hawaii.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Judith

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Telephone 808-453-6946

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Footnotes:

NOT FINAL

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Virginia Pressler, M.D.

Signature of CEO or Designee¹: _____

Title: Director, Department of Health

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
[Standard Form LLL \(click here\)](#)

Name	<input type="text"/>
Title	<input type="text"/>
Organization	<input type="text"/>

Signature:

Date:

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

NOT FINAL

Step 1: Assess the Strengths and Organizational Capacity of the Service System to Address Specific Populations.

Hawaii's behavioral health system is largely operated by the state. Most public services in Hawaii are provided by state agencies. The counties provide municipal services and infrastructure, such as fire and rescue, streets, transportation, water and sanitation. The counties may also provide limited human services for their local residents but typically do not provide behavioral health services. The exception would be county police departments, which may have psychologists on staff.

Overview of Hawaii's Behavioral Health System

Hawaii, like many states, faces challenges related to behavioral health. In 2014, 29.4 percent of adults reported having at least one poor mental health day in the previous 30 days, and approximately 17 percent reported having 1 to 6 poor mental health days. In 2014, an estimated 118,700 residents in Hawaii reported being told by a doctor or health professional that they had a depressive disorder (including depression, major depression, dysthymia, or minor depression).¹ Native Hawaiians had the highest rate of depressive disorders (15.8 percent) followed by Whites (15.6 percent). Further, the 2014 Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics Barometer estimated that 3.7 percent of the 38,000 adults aged 18 or older had a serious mental illness (SMI) within the year. Unfortunately, only 32 percent of adults received mental health treatment/counseling within the year. Since behavioral health has been identified as Hawaii's most pressing health care priority, one of the state's goals for the "Healthy Families and Healthy Communities" initiative is to strengthen the health care delivery system to support behavioral health integration by reducing preventable hospitalizations, readmissions, and emergency room visits by 2021.

The state of Hawaii features a health care delivery system that reflects the diversity and history of the State's 1.4 million residents and seven different inhabited islands. Because the majority of residents live on the island of O'ahu, the State's acute care hospitals have a concentrated presence there. The community providers in the State also provide a range of services and the bulk of the primary medical and dental services provided in underserved areas. Finally, a majority of the State's providers are independent practitioners working in small practices. Overall, the State's hospitals, providers, and payers are moving towards a health care delivery system that pays for quality outcomes rather than units of services.

Federally-Qualified Health Centers (FQHCs): Hawaii has fourteen Federally-Qualified Health Centers on six islands that provided care for 150,000 patients in 2016. The FQHCs serve the rural and low-income residents on all six islands who would otherwise lack access to primary care services. The FQHCs are the largest provider network for Medicaid and second-largest provider source of direct primary medical services in the state. The FQHCs in Hawaii provide behavioral health care, dental services, language assistance, health education and nutrition counseling, and assistance with program applications such as housing and cash assistance.

Community Mental Health Center (CMHCs): The Hawaii Department of Health (DOH), Adult Mental Health Division (AMHD) operates four state-staffed CMHCs, several with smaller satellite sites, which

¹ Hawaii Health Data Warehouse. 2015. "Health-mental bad past 30 days (BRFSS)." Accessed April 6, 2016.

served approximately 10,000 adults with SMI on all seven main islands in FY 2016. Many of these individuals are covered by Medicaid, uninsured, or conditionally released to the community for ongoing mental health treatment following a court determination of not guilty by reason of insanity for either felony or misdemeanor charges.

Family Guidance Centers: The DOH Child and Adolescent Mental Health Division (CAMHD) operates seven regional Family Guidance Centers (FGCs) with at least in each county, and one Family Court Liaison Branch that serves the state population. FGCs provide services to youth identified as in need of intensive mental health services. Youth are assigned an FGC Mental Health Care Coordinator and may continue to receive School-Based Behavioral Health (SBBH) services and supports from the state Department of Education in addition to the intensive mental health services provided through an FGC.

Medicaid Program: Hawaii uses managed care throughout its Medicaid program, contracting with five health plans. These plans are the Hawaii Medical Service Association (HMSA Blue Cross/Blue Shield), Kaiser Permanente, AlohaCare, 'Ohana, and United Healthcare. HMSA serves the largest portion of the Medicaid population and all serve other populations in Hawaii's health care market. About half of all children in the state are on Medicaid.

The Hawaii Med-QUEST (Medicaid) Division has operated under an 1115 Waiver Managed Care Demonstration since 1994. Five managed care organizations (MCOs) currently contract with Med-QUEST to provide Medicaid benefits to eligible beneficiaries: HMSA, Kaiser Permanente, AlohaCare, United Healthcare, and 'Ohana Health Plan (WellCare). The services under the QUEST and QUEST Expanded programs were enhanced when they were merged and integrated. The Department of Human Services integrated the QUEST and QExA components, which became operational on January 1, 2015. This new program is called QUEST Integration (QI). The goals of QI are to "minimize administrative burden, streamline access to care for enrollees with changing health status, improve health outcomes by integrating programs and benefits, align with the ACA, improve care coordination, and promote independence and choice among members that leads to more appropriate utilization of the health care system." The most significant change for health plans is that they now all served the aged, blind, and disabled (ABD) population.

The transition to QI focuses on a patient-centered approach, allowing patients to obtain services in the most convenient and cost-effective environment. One of the key changes to QI is that both at-risk beneficiaries and beneficiaries that meet an institutional level of care have a choice of either home- or institutional-based services. For the current contract with Med-QUEST, the five MCOs are required to incorporate Value-Based Purchasing (VBP) requirements into their contracts with providers to render health care treatment and services. These requirements also represent the incentives upon which the MCOs may earn additional funding. VBP links a provider's reimbursement to performance, aligning payment with quality and efficiency.

Within DOH, three divisions provide behavioral health services: the Adult Mental Health Division (AMHD), the Child and Adolescent Mental Health Division (CAMHD) and the Alcohol and Drug Abuse Division (ADAD). Generally, individuals must be diagnosed with a serious mental illness, serious emotional/behavioral disturbance or alcohol or drug abuse problem, or be in a state of crisis in order to receive AMHD, CAMHD or ADAD services. The services offered by these divisions may supplement those that are covered by Med-QUEST, although individuals do not need to be covered by Medicaid to qualify

for many services. AMHD, CAMHD and ADAD treat many individuals with intensive needs that may be otherwise covered by the Med-QUEST program.

The State Judicial System

Hawaii's criminal justice system is comprised of two major components: the State Judiciary that is responsible for the population of individuals under court supervision (i.e. probation, conditional release, and drug courts) and the Department of Public Safety, which is responsible for the population of incarcerated individuals. The Judiciary's First Circuit **Mental Health Court (MHC)** was established in response to the overrepresentation of people with mental illness in the criminal justice system, and the difficulties associated with managing this particular population. Defendants with mental illness released to the community on supervision have difficulty adhering to the terms and conditions of probation. This population has extensive treatment and service needs that require supervision strategies that traditional courts are not designed to provide. The First Circuit MHC redirects offenders from jail to community-based treatment with intensive supervision to ensure public safety and to support the recovery of defendants diagnosed with severe mental illness.

In this collaborative program, community treatment providers' offer specialized care for participants requiring psycho-social rehabilitation, psychiatric treatment, substance abuse recovery, and other individualized treatment. Upon admission to the MHC program, participants redirected from incarceration to treatment receive multiple benefits that may include treatment and supervision support, reduced jail sentences, and possible early termination of probation or dismissal of charges.

The **Community Outreach Court** administered and operated by the Judiciary in the City and County of Honolulu was established January 2017 and has received funding from the legislature for this pilot project as of July 1, 2017. Its goal is to help nonviolent offenders who face problems such as drug abuse and mental health challenges to obtain basic services and necessities, like food, shelter, and treatment, thereby reducing crime and recidivism. Many of those arrested for offenses such as drinking liquor in public, being in public parks after hours of closure, and camping on sidewalks, beaches, and other restricted public places do not come to court, which leads to the issuance of bench warrants for their arrest.

Once these offenders are brought into court, the sentences imposed are often monetary fines, as the offenses are not usually serious enough to warrant incarceration. However, most offenders have little or no income and are unable to pay the fines. This noncompliance leads to another bench warrant, which repeats the cycle and keeps the offenders in the system without offering any rehabilitative measures. In addition, the prosecution of these cases burdens and congests the court system without producing a meaningful resolution that will prevent recurrence of the offenses.

The Community Outreach Court is intended to function as a mobile justice system that travels to neighborhoods and resolves cases against offenders who may suffer psychological conditions that make it difficult for them to attend a traditional court setting or pay fines imposed. The community court is also intended to impose alternative sentences such as community service and mandatory participation in programs deemed appropriate for individual offenders based on their need for specific mental health services, substance abuse treatment, sustenance, and shelter.

ADULT MENTAL HEALTH SYSTEM

The Hawaii Department of Health, Adult Mental Health Division (AMHD) is considered the State Mental Health Authority (SMHA) that manages mental health services for consumers with serious mental illness, who are uninsured or underinsured, those who are court ordered, and individuals in crisis. The AMHD is under the Hawaii State Department of Health (DOH), Behavioral Health Administration (BHA). BHA also includes the Alcohol and Drug Abuse Division (ADAD), the Child and Adolescent Mental Health Division (CAMHD), and the Developmental Disabilities Division (DDD).

The AMHD or SMHA provides services to adults through the state operated Community Mental Health Centers (CMHCs), the Hawaii State Hospital and Purchase of Service providers through state procurement contracts. The AMHD uses state general or special funds to provide services to only adults meeting the definition of having a serious mental illness (SMI). SMI individuals who are eligible for SMHA services with low-income or without health insurance also receive mental health services through Medicaid's QUEST Integrated program.

Cultural competency is also integrated into AMHD services through a set of congruent policies, procedures, staff training and conferences that enable effective service delivery with consumers of diverse backgrounds. The guiding principles of the AMHD reflect the culture of our organization and state the way we deliver services. The guiding principles also apply to persons with SMI, who have co-occurring medical conditions, substance use disorders, homelessness, and an involuntary civil or a penal commitment status.

The AMHD includes clinical and administrative lines of authority and oversight responsibility under the leadership of the AMHD Administrator. The AMHD Psychiatry Chief supervises the clinical lines through the statewide services coordinators (SSCs), who have statewide responsibility for the development of services, program standards, and policies and procedures, according to evidence-based practices and professional standards. The SSCs also provide coordination with relevant agencies to their service specialty; determining contract scopes of services, and provision of training and technical assistance for the AMHD system of care. The specialty areas of the five SSCs are: 1) Crisis Services and Specialized Treatment Facilities; 2) Community-Based Case Management, Community Support Services, and Psychosocial Rehabilitation/Clubhouses; 3) Community Housing; 4) Mental Illness/Substance Abuse (MISA) and Special Populations (including Transition-Age Youth, Trauma, Older Adults, and Co-Occurring Cognitive Impairments) and; 5) Continuity of Care. In this organizational context, Utilization Management and Performance Improvement are also considered part of the clinical lines.

The AMHD eligibility criteria are organized into the following three categories: Category I: Continuing Services; Category II: Time Limited Services (including, but not limited to, Homeless and Crisis Services); and Category III: Disaster Services. Formerly more inclusive, the primary focus of the current eligibility criteria became individuals who were diagnosed with a severe and persistent mental illness, who may also have co-occurring mental and substance use disorders, and those who are legally encumbered. Individuals must continue to demonstrate significant functional impairment, one that seriously limits their ability to function

Opportunities for the clinician to gain an understanding of the person and for the person served to access the most appropriate mental health services; an assessment of the person's physical,

psychological, and social functioning status is conducted for admission to the AMHD. For individuals ages 18 and older who are seeking mental health services, the World Health Organization Disability Assessment Schedule (WHODAS) 2.0 is used in assessing disability. Individuals must also: 1) live in Hawaii and be a citizen of, or have permanent residency status in the U.S.A., 2) fall within similar assets/income requirement for Medicaid, and 3) meet a delineated insurance status or continue to be without insurance coverage.

Below is the number of consumers served by AMHD in FY 2016:

Table 1
Number of Adults Served, FY2016

FY2016 Adult Consumers Served				
Age	Female	Male	Not Available	Total
0-12 Years	0	0	0	0
13-17 years	4	3	1	8
18-20 years	90	83	1	174
21-24	176	115	6	297
25-44	1449	1041	12	2502
45-64	2200	1608	3	3811
65-74 years	338	358	0	696
75+ years	68	89	1	158
Not Available	1	0	0	1
Total	4326	3297	24	7647

Adult Mental Health Division's Array of Services

CASE MANAGEMENT/SUPPORT SERVICES

Community-Based Case Management (CBCM): Community-Based Case Management services coordinate services for the individual living with mental illness. A professional is responsible for the assessment of need, care planning, implementation of care plans and the regular review of services to assist the individual's recovery. Case management services could include: assistance to acquire health insurance; coordination of medical, health, and coverage benefits; assist with acquiring/maintaining housing; maintain and foster contact with the family; consumer supports and collaterals, and advocate on behalf of the consumer.

- Islands served: Oahu, Hawaii, Maui, Molokai, Lanai, and Kauai

Homeless Outreach: This service identifies and engages with homeless individuals with mental illness

and provides the support necessary to link them with formal mental health and social services. Homeless Outreach workers interact with homeless individuals, who are suspected of having a mental illness and assist them to obtain an Eligibility Determination and appropriate linkage into services.

- Islands served: Oahu, Hawaii, Maui, and Kauai

Peer Coach: Peer coach services provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and development and maintenance of community living skills through the eyes of someone who received or is receiving mental health services. Peer coaching involves providing increased attention and support to consumers when they are under high stress, beginning to decompensate, or returning to the community after a hospitalization.

- Islands served: Oahu, Hawaii, Maui, and Kauai

Representative Payee: The Representative Payee Program is intended to provide money management for registered consumers who have the capability to learn how to manage their own finances within two (2) years of initial services authorization. It is an educational component of our community recovery services which teaches the consumer how to budget, save, and pay bills. The consumer learns to manage their financial resources and to be responsible for the debt they incur.

- Islands served: Oahu, Hawaii, Maui, and Kauai

COMMUNITY HOUSING

24 Hour Group Home: The 24-hour Group Home provides twenty-four (24) hours a day, seven (7) days a week supervision. Services are directed to consumers being discharged from the hospital and to consumers who, without twenty-four (24) hour care, would further decompensate and increase their likelihood of hospitalization. It is also directed to consumers whose goal is to move to more independent living options from a higher level of care. This service is designed to be individualized, to integrate individuals into the community to the most normal, least restrictive placement, and to be consistent with the individual's needs.

- Islands served: Oahu, Hawaii, Maui, and Kauai

8-16 Hour Group Home: This housing service is designed to be individualized, to integrate individuals into the community to the most normalized and least restrictive placement, and to be consistent with the individual's needs. Supportive staff is on-site between eight (8) to sixteen (16) hours a day, seven (7) days a week.

- Islands served: Oahu, Hawaii, Maui, and Kauai

Semi-Independent Housing: This housing service provides group living with property management staff on-site eight (8) hours a day, plus some weekend coverage. This service applies to individuals who are capable of handling non-crisis issues for a day or two until a scheduled staff visit. This program is also designed to be individualized, to integrate individuals into the community to the most normalized and least restrictive possible and to be consistent with the individual's needs. The service focuses on home and community integration and enhances the independence, dignity, privacy of the consumer and personal choice.

- Islands served: Oahu, Hawaii, Maui, and Kauai

Shelter Plus Care (S+C) for the Homeless: This is a United States Department of Housing and Urban Development (HUD) rental subsidy program in which a residential specialist locates housing for homeless individuals with severe and persistent mental illness. Housing is selected by consumers with 24-hour housing support team available to landlords and consumers. The rental subsidy allows

consumers to pay no more than 30 percent of their entitlements for rent.

- Islands served: Oahu, Hawaii, Maui, Molokai, and Kauai

Supported Housing/Bridge Subsidy: Supported housing provides consumers the option to live in permanent housing of their choice with service to successfully assume the role of tenant and neighbor. This occurs in settings where an individual can live either alone, with a relative, or with friends in a home or apartment without regularly structured supervision from supported housing and mental health staff. Mental health staff provides support that is separated from the living arrangements but in-home support is encouraged as needed.

- Islands served: Oahu, Hawaii, Maui, Molokai, and Kauai

Therapeutic Living Program (TLP): The TLP provides ongoing residential/treatment support for individuals that are not ready to manage their medication in a more independent housing setting. Nursing services are available on site during the week, including support for basic physical health and medication management. Some Psych-social Rehabilitation Programming is provided on-site but residents are encouraged to engage in community-based support such as Clubhouse or Day Treatment.

- Island served: Oahu

Transitional Housing, Safe Haven: This HUD-funded transitional housing program, called Safe Haven is primarily for homeless consumers. Twenty-four (24) hour supervision is provided along with primary care and case management services.

- Islands served: Oahu, Hawaii, Maui

CRISIS SERVICES

Crisis Line of Hawaii: This is a 24-7 Crisis and Suicide Hotline with membership in the National Suicide Prevention Lifeline (SAMHSA). The Crisis Line staff provides supportive listening and crisis counseling, dispatch and authorization of 24-hour crisis services, and serves as the after-hour's link for oral *Ex-Parte* orders.

- Islands served: Statewide

Crisis Mobile Outreach (CMO): CMO provides assessment and intervention services for adults in an active state of crisis. This service is available twenty-four (24) hours a day, seven (7) days a week and can occur in a variety of settings including the consumer's home, local emergency department, etc. This service provides an opportunity for immediate crisis intervention and de-escalation, which includes a thorough assessment of risk, mental status and medical stability, and exploration of service options in the community.

- Islands served: Oahu, Hawaii, Maui, Molokai, Lanai, and Kauai

Crisis Support Management (CSM): CSM provides time-limited support and intervention services to individuals who are in crisis and not linked with services or who do not have a Division-assigned case manager. Services assist the individual in returning to a pre-crisis state and gaining access to necessary services.

- Islands served: Oahu, Hawaii, Maui, Molokai, Lanai, and Kauai

Licensed Crisis Residential Services (LCRS): The LCRS offers short-term, acute interventions to individuals experiencing or recovering from a psychiatric or behavioral health crisis. This is a structured residential alternative or diversion from psychiatric inpatient hospitalization. LCRS services are for

individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. This program provides services which address the psychiatric, psychological, and behavioral health needs of the individual.

- Islands served: Oahu, Maui, Hawaii

FORENSIC SERVICES

Clinical Assessment & Referral Services: Court Based Clinician: Clinical assessment and referral services in the District Court are provided by a Court Based Clinician. The Court Based Clinician provides services in support of AMHD's mission to coordinate and promote integrated mental health services to individuals with serious mental disorders, many of whom have criminal justice involvement. The primary purpose of this position is to provide consultation and liaison services to courts and criminal justice agencies; evaluate and monitor consumers with severe and persistent mental illness (SPMI) and criminal justice involvement regarding their risk level, engagement with treatment planning determining eligibility based on psychological evaluation, and adherence to court ordered conditions; and provide recommendations regarding risk management and reduction strategies to support maintenance of community tenure. This position serves as a technical expert regarding admission procedures and eligibility criteria for mental health programs (i.e. post-booking jail diversion, and Oahu Mental Health Court).

- Island served: Oahu

Community-Based Fitness Restoration: This program provides fitness restoration in a community setting, after a defendant has been released on conditions to the community on a 704-406(1) legal status. This program is an alternative approach to restoration in a hospital setting. Outpatient competency restoration offers an effective alternative to lengthy hospital commitments for consumers who can safely be restored to fitness within a community setting. Like Hale Imua, the program is tailored to meet the unique needs of each individual, including linkages to community programs and resources, such as Clubhouses.

- Islands served: Statewide

Conditional Release Exit Support and Transition Program (CREST): This program provides an avenue for consumers on Conditional Release (CR) to prepare for potential discharge from CR. It involves a multi-session group format with a primary focus on identifying warning signs, triggers, crisis plans and other issues related to life after CR. Additional support and resources are provided to consumers to understand the court system and other parties that are involved in the legal process.

- Islands served: Statewide

Consultation/Liaison with Law Enforcement and Public Safety Department: AMHD provides support for training law enforcement first responders with the skills needed to effectively interact with people who are mentally ill and those in crisis and delivering effective services in the crisis context. This service takes the form of mental health consultation and liaison by Mental Health Emergency Workers (MHEW). Service delivery of consultative services varies by county. In Honolulu County, Honolulu Police Department employs police psychologists to serve as a MHEW with financial support for the program provided by AMHD. Maui County has developed a formal Crisis Intervention Team (CIT) program that receives consultation from Crisis Mobile Outreach teams. Both Hawaii and Kauai counties have developed informal arrangements for consultation between law enforcement personnel and the local

mental health authority. AMHD collaborates with the Public Safety Department Corrections Division in providing consultation on challenging clinical cases involving detainees and inmates with mental illness and through the MH-9 process, the ability to transfer a person to Hawaii State Hospital from a correctional facility when hospital level of care is indicated.

- Islands served: Statewide

Consultation to Specialty Courts– Mental Health Court (MHC): The Mental Health Court team is led by the Hawaii State Judiciary in collaboration with staff from the Department of Health, Adult Mental Health Division who provide clinical support to the team. The Court Based Clinician serves as the liaison to criminal justice and other community agencies regarding the interface between mental health and criminal justice issues including risk assessment, management and reduction. The Court Based Clinician provides initial clinical evaluations and re-evaluations specifically related to referrals and current Mental Health Court participants.

- Island served: Oahu

Court Ordered Forensic Evaluation Services (Court Evaluation Branch): Court evaluation and liaison services are delivered through the AMHD Court Evaluation Branch which provides consultation services to the Judiciary in accordance with Hawaii Revised Statutes (HRS). The Branch maintains a list of certified examiners for the Judiciary. Examiners perform court ordered evaluations of adults for Circuit and District Courts statewide pursuant to HRS 704 including examination of mental disease, disorder or defect; fitness to proceed; penal responsibility; risk assessments to assist in the court's disposition related to discharge, release on conditions, or commitment to the custody of the Director of Health; and examination of the mental condition of a defendant to assist in the court's disposition of an application for discharge, conditional release, modification of conditions of release, or discharge from conditional release. Examiners also perform court ordered evaluations of juveniles for Family Court. Examiners prepare relevant reports and provide testimony in support of court ordered evaluations.

- Islands served: Statewide

Forensic Coordination: Services are provided by Forensic Coordinators who are psychologists. The function of the Forensic Coordinators is to provide coordination and consultation regarding court related elements of treatment and follow-up for persons receiving AMHD services who are involved with the criminal justice system. The primary purpose of the Forensic Coordinators is to provide consultation and liaison services to treatment teams and criminal justice agencies; evaluate and monitor consumers with severe and persistent mental illness (SPMI) and criminal justice involvement regarding their risk level, engagement with treatment planning and adherence to court ordered conditions; and provide recommendations regarding risk management and reduction strategies to support maintenance of community tenure. Forensic coordinators also oversee the Jail Diversion Program, the Community Fitness Restoration Program and the Conditional Release Transition Program.

- Islands served: Statewide

Hale Imua: This program serves criminal justice involved consumers on Conditional Release (CR) status and its programming is based on a multidisciplinary approach to integrated treatment in a safe setting focusing on the consumer's strengths. The program is tailored to meet the unique needs of each individual including linkages to community programs and resources. The model is based on a continuity of care incorporating evidence-based practice techniques including classes that address recidivism. Each resident is provided with comprehensive clinical team that includes psychiatrist, psychologist, nurse, and

case management. This is a state pilot project that started in 2005 and services are primarily supported by the Windward Treatment Services Section staff. Hale Imua is implemented in a 24-hour group home setting focusing on a consumer's strengths.

- Island served: Oahu

Honolulu Police Department (HPD) Central Receiving Division Services: This program provides two Advanced Practice Registered Nurses (APRNs) for up to 80 hours per week (2 FTE) at the HPD's Central Receiving Division (CRD). The APRNs work in partnership with the Crisis Line of Hawaii, which provides the capability to cross-reference individuals and determine if they were currently receiving AMHD services. Information about arrests is relayed from the Crisis Line of Hawaii back to the case management team for follow-up. Major activities include reviewing medication and medication needs and making recommendations to the court on behalf of the consumers, and providing the court with community treatment alternatives to hospitalization.

- Island served: Oahu

Pre-Booking Jail Diversion: This program operates as a joint effort between the AMHD and the Honolulu Police Department (HPD). When a person is suspected of mental illness at a crime scene, the HPD officer can request consultation from one of three HPD-employed psychologists who have been designated by the Director as Mental Health Emergency Workers and who are available for consultation 24-hours a day.

See Consultation/Liaison with Law Enforcement and Public Safety Department below for additional information. Consultation services to law enforcement provide additional diversion opportunities.

- Island served: Oahu

Post-Booking Jail Diversion: Post-Booking Jail Diversion is a supportive case management service provided for potential consumers in post-booking and pre/post arraignment situations. The intent of this service is to reduce criminal recidivism by diverting eligible, non-dangerous mentally ill arrestees and detainees from incarceration. The service provides and/or coordinates outreach and therapeutic support to eligible consumers in accordance with evidence-based best practices to assure each consumer's jail diversion plan addresses legal, public safety, and community tenure issues. The service coordinates activities that eligible consumers obtain basic needs including food, housing, clothing, transportation, and money; apply for and receive benefits and entitlements and have access to peer support and recovery opportunities.

- Islands served: Oahu, Hawaii, Maui, Molokai, Lanai, and Kauai

PSYCHOSOCIAL REHABILITATION SERVICES

Clubhouse: The Clubhouse Model of Psychosocial Rehabilitation is a comprehensive and dynamic program of support and opportunities for people with severe and persistent mental illness. In contrast to traditional day-treatment and other day program models, Clubhouse participants are called "members" (as opposed to "patients" or "clients") and restorative activities focus on their strengths and abilities, not their illness. The Clubhouse is unique in that it is not a clinical program, meaning there are no therapists or psychiatrists on staff. All clinical aspects of the program have been removed so as to focus on the strengths of the individual, rather than their illness. Additionally, participation in a Clubhouse is strictly on a voluntary basis. The members and staff of a Clubhouse work side-by-side to manage all the operations of the Clubhouse, providing an opportunity for members to contribute in significant and meaningful ways; therefore, a Clubhouse is operated in a partnership model with members and staff working side-by-side as colleagues. The Clubhouse Model seeks to demonstrate that people with mental illness can successfully live productive lives and work in the community, regardless

of the nature or severity of their mental illness. Clubhouse services include Transitional Employment (TE), Group Transitional Employment (GTE), Supported Employment (SE), Supported Education (SE), Advocacy and Case Management.

- Islands served: Oahu, Hawaii, Maui, Molokai, and Kauai

Hawaii Certified Peer Specialist Program: The primary goal of the Adult Mental Health Division (AMHD) Hawaii Certified Peer Specialist (HCPS) program is to provide interns with the basic knowledge and skills for direct-care human service employment with an AMHD agency. The field placement/internship experience provides an environment for continued growth and the practical application of skills learned. A HCPS is a person who has not only lived the experience of mental illness, but also has had formal training in the peer specialist model (Georgia's Model) of mental health supports. Interns must pass HCPS examinations, both oral and written, after approximately 80 hours of training. They are prepared for employment as Certified Peer Specialists, Peer Educators, or Peer Coaches in the evolving healthcare environment. A subgroup of HCPS have received specialized training and certification as Forensic Peer Specialists. Forensic Peer Specialists provide peer support that is offered to individuals with psychiatric and/or co-occurring challenges who are involved in the Criminal Justice System, from initial contact with law enforcement through re-entry into the community.

- Islands served: Statewide

Supported Education (SE): This Clubhouse service provides consumers with a full range of educational services from basic literacy through gaining of a General Equivalency Diploma (GED) to educational counseling for college, technical education or other courses. Necessary supports are provided such as study skills training and social skills training.

- Islands served: Oahu, Hawaii, Maui, Molokai, and Kauai

Supported Employment (SE): Supported employment is based on models of: 1) "Individual Placement and Support (IPS)," a "place-train" approach, or, 2) "choose get, keep and leave (jobs)" as opposed to engaging in pre-vocational training. These services are intended for consumers for whom competitive employment has not traditionally occurred, or has been interrupted, or intermittent as a result of their disability. Supported employment is paid, competitive work that offers ongoing support services in integrated settings for consumers and their employers. Elements include zero exclusion, consumer preference, rapid job search, integration with mental health services; and personalized benefits planning.

- Islands served: Oahu, Hawaii, Maui, and Kauai

Transitional Employment (TE): This Clubhouse service offers members the opportunity for paid employment various hours a day and lengths of time depending on individual needs. Clubhouse staff assumes the paid TE job in the member's (temporary) absence.

- Islands served: Oahu, Hawaii, Maui, Molokai, and Kauai

TREATMENT SERVICES

Day Treatment: This service is a structured day program for individuals diagnosed with co-occurring, mental illness, and substance abuse use disorders (MISA). The programming consists of three or six hours of treatment per day depending on the assessed clinical needs of the consumer. Day treatment is designed to assist the consumer with developing illness management skills to prevent relapse to substances, increase strategies to cope and/or manage severe symptoms of mental illness and improve overall life skills deficits.

- Islands served: Oahu, Maui

Hospitals (Inpatient, General, Non-Forensic): The provision of inpatient care within a unit designed to service seriously mentally ill patients who have just been admitted or are experiencing an acute phase of their illness in the course of an extended hospitalization. Services are primarily oriented toward developing a differential diagnosis, developing treatment plans to fully respond to the acute needs and stabilization of the patient's psychiatric condition, and intensive intervention.

- Islands served: Oahu, Hawaii, Maui, and Kauai

Hospitals (Inpatient, Specialty/State, Forensic): The provision of secure care within a hospital setting that is designed to: 1) serve seriously mentally ill patients who require secure care beyond the acute phase of their illness with psychiatric rehabilitation services with the goal of achieving the highest level of functioning possible before returning to community living; 2) serve patients who are committed by a court to evaluate competency to stand trial, assess criminal responsibility, or provide recommendations to the referring judge or county department regarding court disposition or department resolution; 3) provide psychiatric treatment and fitness restoration to enable patients competent participation in court proceedings; 4) provide recommendation to the referring judge or county department to facilitate court disposition.

- Island served: Oahu (Hawaii State Hospital)

Intensive Outpatient (IOP) Hospital: IOP outpatient hospital services for the purpose of providing stabilization of psychiatric impairments as well as enabling the individual to reside in the community or to return to the community from a more restrictive setting. The goals of the service are clearly articulated in each consumer's individualized plan of care. Treatment is time-limited, ambulatory, active, and offers intensive, coordinated clinical service, which is provided by a multi-disciplinary team.

- Island served: Oahu

Outpatient Treatment: Outpatient Clinic Services include an array of services that are provided to the consumer in an outpatient clinic setting in combination with CBCM. Interventions include medication management, prescribing, monitoring, and administration along with evidence-based integrated substance use treatment and trauma-informed care to persons with severe and persistent mental illness. Services include community case management of individuals of varying levels of care in the community, including those with forensic encumbrances in conjunction with judicial partners. Individual therapy, group therapy, family therapy, and psycho-education interventions are designed to promote self-efficacy and build independent living skills.

- Islands served: Oahu, Hawaii, Maui, Molokai, Lanai, and Kauai

Specialized Residential Treatment - Mental Health: This service is a residential program which has a goal to increase the consumer's independent functioning in the community living work settings. The continuum of care includes: observation, monitoring, and treatment twenty-four hours a day, seven (7) days a week. This service is also designed for consumers who have co-morbid medical conditions, including physical disabilities, who have suffered the effects of institutionalization in long-term psychiatric hospitals, and who may require unique and highly specialized services that do not typically exist in the community.

- Islands served: Oahu, Maui

OTHER SERVICES

Expanded Adult Residential Care Home (E-ARCH): This is a care home placement service supported by RN and psychiatric case managers. It primarily serves to successfully discharge AMHD consumers who are currently residing in the hospital (Hawaii State Hospital, Kahi Mohala, Castle and Queen's Medical Center), who meet the intermediate care facility (ICF) level of care and are appropriate for admission to an E-ARCH.

- Island served: Oahu

Primary & Behavioral Health Integrated Care: The integrated primary and behavioral health care "Living Well Hawaii" project serves Hawaii residents with severe mental illness (SMI) who receive healthcare services from the state-operated West Honolulu (Kalihi Palama CMHC), and the Leeward (Central Oahu CMHC) in collaboration with the Kalihi Palama Community Health Center (CHC). The project integrates primary healthcare into the behavioral health service setting to increase access to comprehensive healthcare and improve the health status and outcomes of individuals with a severe mental illness, co-occurring substance use disorders and medical co-morbidities. Kalihi Palama Health Center's primary healthcare providers and AMHD Community Mental Health Center behavioral healthcare providers collaborate in providing integrated "whole person" health services to enrollees. The project is jointly funded by the State of Hawaii Department of Health (DOH) and a four (4) year federal Substance Abuse and Mental Health Services Administration grant awarded to the DOH, Adult Mental Health Division.

- Island served: Oahu

STRENGTHS OF THE AMHD SERVICE SYSTEM

Continuity of Care Program

The primary function of this service is to coordinate a statewide system of services for adults with SMI and to address AMHD's enhanced mission to focus on "recovery into independence." It promotes continuity of care wherever the consumer intersects with the criminal justice system, admission into AMHD services until discharge (including Hawaii State Hospital (HSH) and the Community Mental Health Centers). This service also addresses continuity within AMHD services, but develops and sustains positive alliances with key stakeholders from criminal justice, judiciary, law enforcement agencies, community hospitals, Purchase of Service providers (POS), and other medical and mental health agencies statewide. Compliance has increased to 90% of case managers' attendance at hospital recovery plan review meetings.

E-ARCH Program

The AMHD Expanded Adult Residential Care Home (E-ARCH) Program was initiated as a continuity of care project to address the rising census at the HSH. The program focused on discharge of patients residing at HSH who did not meet acute psychiatric criteria, yet had no appropriate AMHD funded level of care for discharge. On a case-by-case basis, usually because of forensic encumbrance, other facility referrals have been approved for the AMHD E-ARCH Program consumers admitted to Kahi Mohala, Licensed Crisis Residential Services (LCRS), Specialized Residential Services Program (SRSP), and other hospitals including Castle Medical Center, the Queen's Medical Center, and Pali-Momi Medical Center.

Currently there are 42 consumers participating in the AMHD E-ARCH Program. There are approximately 25 licensed E-ARCH care givers and five private pay RN case managers contracted with AMHD for this service. Education and Training continues to be provided to the care giver, their staff and the private

pay RN case managers. Course topics on therapeutic relationships, boundary setting, psychiatric diagnoses, co-morbidity, community risk assessment, and self-defense are taught by seasoned professionals including psychiatrists, psychologists, nurses, and community leaders.

One ongoing challenge for this program is the need for utilization management and administrative program support. This program has been recognized for its commitment to working with providers and supporting consumers as they move out of the hospital and into a community-based home setting. As the population ages, more geriatric psychiatric care options are needed such as an AMHD funded adult residential care home (ARCH) program and a larger 24/7 operated psychiatric intermediate care facility (ICF), and mobile psychiatry and physician services.

Emergency Room Usage/Criminal Justice Front Door Diversion/Collaboration

The Honolulu Emergency Psychological Services and Jail Diversion Program (HEPSJDP) is partially funded with Mental Health Block Grant funds. This is a collaborative project of the Honolulu Police Department (HPD), the Hawaii State Department of Health, Honolulu Emergency Medical Services, the Queens Medical Center, Castle Medical Center, Tripler Army Medical Center, and the Institute for Human Services. The program has been funded with federal, state and city resources. The goals of the program are:

- To provide access to emergency psychological service for any person in crisis who meets a law enforcement officer;
- To divert adults with mental illness away from the criminal justice system and into treatment whenever possible;
- To collaborate with governmental and other agencies to fully implement requirements of Hawaii Revised Statutes;
- To develop a plan of sustainability of this project through collaboration between governmental and other agencies, such as the State Department of Health, the State Department of Public Safety, the Honolulu Police Department and other law enforcement agencies, and
- To refine and maintain a data and tracking system that records all interactions and outcomes between law enforcement and persons in crisis in a manner that allows for outcome and trend analysis.

Police Officers are trained to recognize individuals in crisis whether the person is mentally ill or emotionally disturbed. Additionally, Advanced Practice Registered Nurses (APRNs) are in the Central Receiving Division cellblock to assist individuals with SMI to provide physical and mental health screenings, first aid or emerging medical services and treatment when needed.

In May 2017, 2,213 detainees were counted in the cellblock. Of those 54 percent exhibited symptoms of mental illness, 67 percent were arrested on misdemeanor/petty misdemeanor charges, and 49 percent were arrested on warrants. Ninety percent of detainees had successful linkages to existing mental health services. Data collected by the HEPSJDP continues to show that many individuals with mental illness are still being arrested and do not receive mental health treatment. This results in an increase in severity of mental illness and leads to risk of harm to themselves, the public and police officers.

Homeless Intensive Case Management-Plus Pilot

On May 1, 2017, the AMHD launched the Homeless Intensive Case Management (HICM) Pilot Project Program for homeless consumers. The team consists of a Case Management Team Leader, Psychiatrist

or Advanced Practice Registered Nurse with Prescriptive Authority, and a Hawaii Certified Peer Specialist. The team provides support at an intensity level between what is provided through Assertive Community Treatment and Intensive Case Management (ICM) services. A primary goal of this project is to provide rapid linkage with continuing support services for homeless individuals who are frequently being arrested, or are the subject of frequent calls for an MH-1 (Emergency Examination: Application by Police Officer) and are not otherwise connected with continuing mental health services. Personalized strategies are utilized for consumers to manage their mental illness and utilize their support system to assist in an informed manner is a natural by-product of this service. The HICM Pilot Project also provides case management services, including psychosocial rehabilitation services, housing, social networks, employment, education, physical health, and mental health services.

The System Addresses the Needs of Diverse Population

The AMHD offers a wide range of behavioral health services and the continuum of care spans from services that are more restrictive to those that are less restrictive. Services are provided to all eligible individuals including racial and ethnic minorities, the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community, Native Hawaiians, and other historically underserved populations. Services provided by county are:

Racial and Ethnic Minorities

The AMHD served 7,647 consumers for FY2016, of which 10 percent are Native Hawaiians and Pacific Islanders. With limited resources and staffing, the AMHD has focused on opportunities to integrate the needs of this population into existing programs, planning and policy efforts and by improving collaboration with other state and local partners to provide services for racial and minority groups.

According to the 2016 U.S. Census, approximately 26.7 percent of Hawaii's population belong to a racial or ethnic minority group, i.e. Hawaiians or Pacific Islanders, Black or African Americans, Hispanic or Latino, and the Compact of Free Association (COFA) migrants. The race/ethnic group most commonly reported as experiencing more health problems than average was Native Hawaiians, followed by other Pacific Islanders. According to the Healthcare Association of Hawaii Needs Assessment Report, two mental health indicators exhibit race disparities. In 2016, the largest disparity is for suicide death rate, where the Native Hawaiian/Pacific Islander group (31.2 deaths/100,000 population) has a rate that is nearly three times higher than the overall population in the state (10.9 deaths/100,000 population).

In Hawaii, there is a growing concern over the impact of COFA migrants that includes Federated States of Micronesia, Republic of Marshall Islands, and Republic of Palau. Under the compact, COFA migrants are designated as legally residing non-citizen nationals who are able to freely live and work in the U.S. There have been reports of high rates of morbidity due to chronic disease, such as diabetes, obesity, and smoking. There also have been reports of communicable diseases, such as tuberculosis, Hansen's disease/leprosy, and other medical concerns, which may be related to U.S. nuclear tests conducted in the Pacific nations. In 2014, the social, health, educational and welfare costs attributed to the estimated 14,700 COFA migrants in Hawaii was \$163 million dollars.

LGBTQ Community

Persons of diverse sexual orientation and gender identity are accepted at shelters and special accommodations are made to support them in those settings. As part of a LGBTQ's consumer recovery plan, if the consumer needs additional supports than are available in the AMHD service array, they are referred to local gay and transgender community support groups. At present, upon admission, a new consumer is asked for their preferences, (i.e. how they would like to be addressed, gender they identify with, types of treatment approaches that are preferred, etc.).

To address the needs of Hawaii's diverse population, the Hawaii Department of Health (DOH) has designed a new Strategic Plan 2015-2018, with one of the Strategic Priority, which frames the work of respective programs within the department to focus on "Improving Connections between Primary Care and Behavioral Health." The DOH has made it a priority in integrating behavioral health services into primary care settings, where timely access to behavioral health services is needed. The DOH plans to work with community partners to provide training and ongoing learning opportunities to improve the capacity of primary providers to screen for, identify, and address behavioral health in their practices; implement systems change to facilitate seamless referrals between primary care providers (PCP) and behavioral health specialists for patients with serious mental health conditions; expand access to health information technology for PCPs and behavioral health providers to ensure timely sharing of patient information and care coordination; and strengthen the healthcare delivery system to support behavioral health integration.

To attain these goals, the DOH plans to:

1. Implement the Screening, Brief Intervention, and Referral to Treatment (SIBRT) model, which is a universal screening and counseling tool for tobacco, alcohol, and substance use through primary care providers, with referral to treatment services.
2. Deploy the Improving Mood Providing Access to Collaborative Treatment (IMPACT) model to identify and treat mild-to-moderate depression and anxiety in primary care practice settings.
3. Improve outcomes for chronic health conditions in individuals with SMI enrolled in the Living Well Project.

CHILDREN'S MENTAL HEALTH SYSTEM

Hawaii's child serving system is generally centralized at the state level. For most operational areas, services are provided and funded by the state. Hawaii's education, health and human services, labor, business and commerce, agriculture, public safety and regulatory functions are largely provided by state government. The four county governments, divided among the islands, provide services such as local law enforcement, criminal justice, emergency response, and infrastructure provision, such as roads and sewers. The counties provide limited health and human service programs.

Child & Adolescent Mental Health Division (CAMHD)

The Child and Adolescent Mental Health Division is charged to provide: 1) preventative health services for children and youth; 2) diagnostic and treatment services for emotionally disturbed children and youth; and 3) provide treatment and rehabilitative services for mentally ill children and youth. Such services are to be delivered at the earliest possible moment after the need for such services is established. All eligible children and youth between the ages of birth and seventeen (0 - 17) receive the necessary mental health services to ensure their proper and full development. (Hawaii Revised Statutes

§321-171). The Child and Adolescent Mental Health Division is required to coordinate the effective and efficient delivery of mental health services to children and youth, including services provided by private nonprofit agencies under contract to the Department of Health, and be responsible for the development and implementation of centralized and highly specialized community-based programs for children and youth. Children's mental health services are provided through a combination of public and private services. Direct services such as clinical oversight and intensive case management are provided by the state, while additional services are provided by a network of private providers under state contract.

The CAMHD through its seven Family Guidance Centers and a Family Court Liaison Branch, herein after referred to as "Branches", provide case management services to youth and families statewide through the assigned Care Coordinator. In addition to the case management services, CAMHD employs licensed clinical staff who provide treatment and clinical oversight for their respective Branch. CAMHD also has the ability to procure needed services from its contracted provider agencies to meet the treatment needs of youth. CAMHD provides services to youth who a) have been certified as qualifying under the Individuals with Disabilities Educational Act (IDEA) for special education services and who are in need of related mental health services to benefit from their free and appropriate public education; and b) youth who meet the eligibility requirements for CAMHD's Support for Emotional and Behavioral Development (SEBD) program.

CAMHD is committed to assuring appropriate and effective services for eligible youth and their families. Services are designed to support youth in their educational program, promote healthy functioning, increase independence, and to build upon the natural strengths of the youth, family/guardian and community. Families/guardians are expected to be active participants in the behavioral support process, given the overwhelming evidence that constructive family participation enhances their youth's progress. Interventions are evidence-based and tailored to address the identified needs of the youth/family. Interventions/plans and progress/outcomes are regularly reviewed and modified, as needed, to effectively achieve goals.

Eligibility Criteria for Children's Mental Health Services

The CAMHD provides timely, consistent, and responsive mental health services in the following categories:

Educationally Supportive (ES) Mental Health Services. ES Mental Health services are available for students with an educational disability who have been determined to be in need of intensive mental health services to benefit from their public education. The services are for students whose complex needs extend beyond their school-based educational program and whose community and home environments require additional specific support via their individualized education program (IEP). The criteria for enrolling a youth in the ES program are Individuals with Disabilities Education Act (IDEA) eligibility, an (Individualized Education Program (IEP) plan with recommendation for services from CAMHD, and an IEP meeting with CAMHD participation to determine the goals of mental health services to be provided. The available mental health array of services are: ancillary services, respite supports, psychosexual assessment, intensive case management, intensive in-home intervention, MultiSystemic Therapy, respite home, community mental health shelter, therapeutic foster home, Multidimensional Treatment Foster Care, therapeutic group homes, independent living program for 16-18 year olds,

community-based residential levels III-I, and hospital-based residential. The services are further defined below.

Support for Emotional and Behavioral Development (SEBD) Program. SEBD is an acronym for the CAMHD's Support for Emotional and Behavioral Development program. CAMHD's unique SEBD designation was suggested by youth who rejected the previous stigmatizing labels. Formerly known as SED (Serious Emotional Disturbance) or Serious Emotional Behavioral Disturbance, CAMHD's SEBD program provides an array of services needed by families to support children and youth with high-end intensive mental health support. Children and youth are eligible if they are ages 3-20, are Hawai'i Medicaid QUEST or Fee-for-Service eligible and have a Child and Adolescent Functional Assessment Scale (CAFAS) or *Preschool And Early Childhood Functional Assessment Scale (PECFAS)* score of 80 or above and an eligible DSM-IV Axis I diagnosis of at least 6 months. The services for SEBD youth are defined below.

MENTAL HEALTH SERVICES FOR CHILDREN

EMERGENCY MENTAL HEALTH SERVICES

24-Hour Crisis Telephone Stabilization: This service serves all youth whose immediate health and safety may be in jeopardy due to a mental health issue. Stabilization provides consultation, referral and the necessary support to dissipate the crisis situation.

Crisis Mobile Outreach: This service provides mobile outreach assessment and stabilization services face-to-face for youth in an active state of psychiatric crisis. Services are provided twenty-four hours per day, seven days per week. Immediate response is provided to conduct a thorough assessment of risk, mental status, immediate crisis resolution/stabilization and de-escalation if necessary.

Therapeutic Crisis Home: Therapeutic Crisis Home provides short-term crisis stabilization interventions in a safe, structured setting for youth with urgent/emergent mental health needs. This service includes observation and supervision for youth who do not require intensive clinical treatment in a psychiatric setting and can benefit from a short-term, structured stabilizing setting. The primary objective of this service is to provide crisis intervention services necessary to stabilize and restore the youth's functioning and return them to their natural setting.

EDUCATIONALLY SUPPORTIVE INTENSIVE MENTAL HEALTH SERVICES

Ancillary Services: Ancillary Services are supportive services that facilitate mental health treatment delivery as outlined in the CSP for time-limited interventions that are not available through existing contracted services. Examples include: transportation services, interpretive services, specific clinical services that are not available through contracted providers and special community programs or classes.

Respite Supports: Respite is the provision of care, arranged by the parent(s) of an identified youth(s) to provide relief to the parent(s)/primary caregiver(s) to help maintain the youth(s) in the home. Respite is integrated with other mental health services, as needed to promote coordinated, effective service delivery to the youth(s) and family.

Psychosexual Assessments: These assessments are specialized diagnostic and evaluation services involving a strengths-based approach to identify youths' needs in the specific context of sexually abusive behaviors that have led to the youth being arrested, charged, or adjudicated for a sexual offense.

Functional Family Therapy: This service is an evidenced-based family treatment system provided in a home or clinic setting for youth experiencing one of a wide range of externalizing behavior disorders (e.g., conduct, violence, drug abuse) along with family problems (e.g., family conflict, communication) and often with additional co-morbid internalizing behavioral or emotional problems (e.g., anxiety, depression).

MultiSystemic Therapy: Multisystemic Therapy (MST) is an evidence-based time-limited intensive family and community-based treatment that addresses the multiple determinants of serious anti-social behavior (including crimes against others and property, aggression and other disruptive behaviors, substance use, and status offenses such as truancy, and curfew violations). Treatment averages 60 hours, over the course of 3-to-5 months. MST treats the youth's entire ecology (home and family, school, peers community) and aims to improve the following targets: 1) Keep youth in their homes, reducing out-of-home placements; 2) Keep youth in school; 3) Keep youth out of trouble, reducing re-arrest rates; 4) Improve family relations and functioning; 5) Decrease adolescent psychiatric symptoms; and 6) Decrease adolescent drug and alcohol use.

Intensive In-Home Therapy: This service is used to stabilize and preserve the family's capacity to improve the youth's functioning in the current living environment and to prevent the need for placement outside the home or a Department of Human Services (DHS) resource family home. It also may be used to re-unify the family after the youth has been placed outside the home, or to support the transition to a new DHS resource family for youth with behavioral challenges. This service is a time-limited focused approach that incorporates family-and youth-centered evidence-based interventions and adheres to CASSP principles. This service may be delivered in the family's home or community. This service also assists families in incorporating their own strengths and their informal support systems to help improve and maintain the youth's functioning.

Intensive In-Home Paraprofessional Support: This service augments Intensive In-Home (IIH) Therapy services by supplying trained paraprofessional personnel who provide intensive support to youth and caregivers for the purpose of averting treatment in a more restrictive environment such as a residential or inpatient treatment setting. This service is offered on a short-term basis, and it must include intervention services such as one-to-one skills training, supportive counseling, positive behavioral support, coaching, modeling, and data collection, along with enhanced supervision. These services must be provided in close accordance with specific goals and objectives as delineated in the youth's Mental Health Treatment Plan. The Intensive In-Home Paraprofessional Support Worker (PSW) will work under the close guidance of the youth's assigned IIH therapist. This is not a standalone service, and it may not be used in a school setting.

Intensive Independent Living Skills: A comprehensive treatment service provided to youth and young adults who need to work intensively on developing a range of skills to prepare for independent living. The youth or young adults live in his/her home setting while participating in the service. This service focuses on developing skills and resources related to life in the community and to increasing the participant's ability to live as independently as possible. Service outcomes focus on maximizing the youth or young adults' ability to manage their illness and their lives with as little professional intervention as possible, and to participate in community opportunities related to functional, social, educational, and vocational opportunities. The amount of time any individual spends in these services will vary, depending on the individual needs.

Independent Living Skills Paraprofessional Support: This service augments Intensive Independent Living Skills therapy by supplying trained paraprofessional personnel who provide intensive support for youth and young adults transitioning to independence. This service is offered on a short-term basis, and it must include intervention services such as one-to-one skills training, supportive counseling, positive behavioral support, coaching, modeling, and data collection. These services must be provided in close accordance with specific goals and objectives as delineated in the youth's Mental Health Treatment Plan. The Paraprofessional Support Worker (PSW) will work under the close guidance of the youth's assigned ILS therapist. This is not a stand-alone service, and it may not be used in a school setting.

Therapeutic Respite Home: This service provides short-term care and supervision for youth with emotional and/or behavioral challenges in a supportive environment as a planned part of their treatment. These homes provide structured relief to the youth to prevent disruptions in the regular living arrangement. The goal of Therapeutic Respite Home services is to provide rest and relief to the youth and to help the youth achieve their highest level of functioning. Therapeutic Respite Home is not provided as a stand-alone service, and there is close coordination of this service with other on-going mental health treatment services.

Multidimensional Treatment Foster Care: An intensive evidence-based, family-based services provided in a foster family setting to youth with a history of delinquent and/or disruptive behaviors and emotional challenges. The two (2) major aims of MTFC are to: 1) create opportunities so that youth are successfully able to live in foster families rather than in group or institutional settings; and 2) simultaneously prepare parents, relatives, or other aftercare resources to provide these same youth with effective parenting so that positive changes made in the MTFC setting can be sustained over the long run. MTFC is an evidence-based treatment intervention which utilizes trained and supervised foster parents to: 1) provide youth in care with close supervision; 2) provide youth with fair and consistent limits and consequences; 3) provide a supportive relationship with the youth; and 4) minimize association with peers who may be a bad influence.

Transitional Family Home: An intensive, short-term community-based treatment service provided in a family home setting for youth with emotional and behavioral challenges. These homes provide a normative, community-based environment with therapeutic parental supervision, home structure, and support for youth capable of demonstrating growth in such a setting. This setting provides a supportive platform for family therapy and treatment to occur with the goal of reuniting youth with their family or other longer term family home. These youth are generally capable of attending their home school or an alternative community educational or vocational program. Such homes may also be beneficial for youth in transition from a more restrictive placement as these homes offer a family-like orientation. This level of care is appropriate for youth in need of treatment placements of six (6) to eight (8) months and/or shorter-term crisis stabilization of one (1) to three (3) months.

Community-Based Residential, Level III: Community-Based Residential programs provide twenty-four hour, seven days a week treatment and supervision in a safe and therapeutic environment. This service provides youth with integrated service planning to address the behavioral, emotional and/or family problems, which prevent the youth from taking part in family and/or community life. Services are provided in the context of a comprehensive, multidisciplinary and individualized treatment plan based on the youth's clinical status and response to treatment. These programs are designed for those youth in need of a structured program that includes onsite education, diagnostic, and treatment services to enhance social skills and activities of daily living that cannot be provided in the community. The treatment primarily provides social, psychosocial, educational, and rehabilitative training and focuses on

family/guardian reintegration. Active family/guardian involvement through family therapy is a key element of reintegration into home, school, and community life. Community-Based Residential programs may be specialized but all programs must treat mental health and substance abuse symptoms.

Community-Based Residential Level II (CBR II): This service provides twenty-four hour care and integrated evidence-based and best practice treatment that address the behavioral and emotional problems related to sexual offending, aggression or deviance, both adjudicated and non-adjudicated offenses, that prevent the youth from taking part in family and/or community life. These programs are designed for those youth who pose a moderate risk to the community and whose need can best be met in a structured program of small group living that includes educational, recreational, and occupational services.

CBR II provides support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth accept full responsibility and be accountable for sexually abusive or antisocial behavior; 5) identify and change cognitive distortions or thinking errors that support or trigger offending; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger re-offending and; 8) provide management of other behavioral or emotional problems including trauma resulting from prior physical, sexual, and/or emotional abuse.

Community-Based Residential Level I: This level provides twenty-four hour locked care and integrated evidence-based treatment that addresses the behavioral and emotional problems related to sexually aggressive or deviant offending behavior, which prevents the youth from taking part in family and/or community life. This program is designed for those youth who pose a high risk to the community and whose needs can best be met in a structured program of small group living that includes educational, recreational, and occupational services.

High Risk Community-Based Residential program Level I provides support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth display responsible and accountable behavior for sexually abusive or antisocial behavior with minimizing risk of reoffending and externalizing blame; 5) identify and change cognitive distortions or thinking errors that support or trigger offending ; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger reoffending and; 8) provide management of other behavioral or emotional problems.

Hospital-Based Residential: Hospital-Based Residential programs offer the highest level of intensive psychiatric and nursing intervention twenty-four hours per day, seven days a week. Hospital-Based Residential service consists of a full range of diagnostic and therapeutic services offered with capability for emergency implementation of medical and psychiatric interventions. This in-patient treatment is designed to treat youth with severe behavioral health conditions that requires rapid stabilization of psychiatric symptoms. This service is required to provide intensive evaluation, medication titration, symptom stabilization and intensive brief treatment of up to sixty (60) days. The highly structured program also provides educational services, family therapy, and integrated service planning through a multidisciplinary assessment of the youth and skilled milieu of services by trained staff. Services are provided in a locked unit of a licensed inpatient facility.

SUPPORT FOR EMOTIONAL AND BEHAVIORAL DEVELOPMENT (SEBD)

Services for youth who qualify under SEBD include all the services above for Educationally Supportive Services and the services described below.

Mental Health Evaluation: This evaluation is a diagnostic assessment which provides needed information concerning a youth's psychosocial functioning. This strengths-based assessment seeks to identify the needs of the youth in the context of his/her family, community, school and/or current treatment program. This service includes interviews, use of assessment instruments, written reports, and feedback to the youth and the caregiver(s).

Psychological Testing: Psychological testing is performed as one component of a Mental Health Evaluation, and it is not authorized as a stand-alone service. Psychological testing is the use of one or more standardized measurements, instruments or procedures to observe or record human behavior, and requires the application of appropriate normative data for interpretation or classification. Psychological testing may be used to guide differential diagnosis in the treatment of mental health disorders and disabilities. Testing may also be used to provide an assessment of cognitive and intellectual abilities, personality and emotional characteristics, and Neuropsychological functioning.

Summary Annual Evaluation: This assessment is performed in order to describe the current status of the youth and his or her circumstances. It is performed yearly, when the Branch Clinical Lead determines that there are no clinical concerns that would call for a more in-depth Mental Health Evaluation. The service includes a brief assessment and report, with feedback to the youth and his/her parent(s) or guardian(s).

Psychiatric Evaluation: Psychiatric diagnostic examination, specifically completed by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist, includes history, mental status exam, physical evaluation or exchange of information with the primary physician, and disposition. This service is limited to an initial or follow-up evaluation for medically complex or diagnostically complex youth. This evaluation does not involve psychiatric treatment or medication management.

Medication Management: Medication Management is the ongoing assessment of the youth's response to medication, symptom management, side effects, adjustment and/or change in medication and in medication dosage. Routine medication management is provided by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist or a Licensed Advanced Practical Registered Nurse with prescription privileges.

Individual Therapy: Individual Therapy is regularly scheduled face-to-face therapeutic services with a youth focused on improving his/her individual functioning. Individual therapy includes evidence-based interventions such as cognitive-behavioral strategies, motivational interviewing, psycho-education of the youth, skills training, safety and crisis planning, and facilitating access to other community services and supports. Data are gathered regularly through self-monitoring, parent monitoring, or frequent administration of brief standardized measures in order to track progress toward meeting treatment goals. These therapy services are designed to promote healthy independent functioning and are intended to be focused and time-limited, with interventions reduced and discontinued as the youth and family are able to function more effectively.

Group Therapy: Group Therapy is regularly scheduled, face-to-face therapeutic services for groups of three or more youth for the purpose of addressing symptoms/problems that prevent the development of healthy functioning in the home, school or community. These therapy services are designed to teach specific skills for addressing the symptoms associated with defined disorders or challenges, to provide support for the use of these skills and to provide psychoeducation about mental health issues. Group Therapy services are focused and time-limited. This service can include groups that address youths' needs utilizing a "multi-family group" format, in which the parents or guardian attend the group along with the youth.

Family Therapy: Family Therapy is regularly scheduled face-to-face interventions with a youth and his/her family, designed to improve family functioning and treat the youth's emotional challenges. The family therapist helps the youth and family increase their use of effective coping strategies, healthy communication, and constructive problem-solving skills. Data are gathered regularly through self-monitoring, parent monitoring, client/parent ratings or frequent administration of brief standardized measures in order to track progress toward meeting treatment goals. Family Therapy sessions may be held in the course of ongoing Individual Therapy with the youth in order to provide opportunities for the therapist to consult with the parent(s) or guardian(s) and review progress toward goals either conjointly with the youth present or separately without the youth present. Family Therapy services are designed to be time-limited with interventions reduced and then discontinued as the youth and family are able to function more effectively.

Partial Hospitalization: Partial Hospitalization is a non-residential day treatment program of a licensed Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certified hospital or behavioral health facility. The environment provides a highly structured, intensive milieu treatment with a focus on medical/psychiatric resources. This level of care provides stabilization of youth with serious emotional disturbances, therapeutically supported diversion from inpatient care, and restoration to a level of functioning that enables a youth's return to the community. Partial hospitalization also provides supportive transitional services to youth who are no longer acutely ill and require minimal supervision to avoid risk. The primary goal of the partial hospitalization programs is to keep youth connected with his/her family/community while providing short-term intensive treatment.

CAMHD'S CONTRACTUAL RELATIONSHIPS

CAMHD provides an array of mental health services through its branches and contracted providers. Referrals are made to contracted provider agencies by the CAMHD Care Coordinator (CC) after a full review of the youth's current strengths and needs as indicated by the admission criteria in the service specific standard as described in the Child and Adolescent Mental Health Performance Standards (CAMHPS). The CC ensures that services are initiated by the contractor in a timely manner as routine services must be initiated within thirty days. All contracted services require prior authorization from CAMHD before service can be provided. With the exception of Emergency Services that must be provided immediately. Without service authorizations Contractors cannot bill for services rendered. The CC is responsible to initiate prompt authorization of services.

It is expected that all youth will have access to needed services. The role of the CC is to make referrals to agencies based on a full review of the youth's current strengths and needs and to ensure that services are initiated in a timely manner. If CAMHD youth from one island is referred to and accepted by an out of home provider on another island, CAMHD will pay for the travel costs for admission, discharge and for CAMHD Branch approved therapeutic passes.

CONTINUITY OF CARE

The DOH's subcontractors are expected, and contractually required, to provide all youth accepted for contracted services with continuity of care until the youth meets the criteria for appropriate discharge or transition to another level of care indicated in team decisions.

STRENGTHS OF THE CHILDREN'S SYSTEM OF CARE

Commitment to the Hawaii CASSP Principles

Based on the input from youth, families and stakeholders, CAMHD adopted the Hawaii Child and Adolescent Service System Program (CASSP) Principles. Nationally, the CASSP principles (Stroul, B.A. and Friedman, R.M., 1986) were developed based on the original work of Jane Knitzer (*Unclaimed Children*, 1982) to provide a framework for systems of care. Early in the 1990's Hawaii communities and stakeholders reviewed and adapted the CASSP principles to ensure the principles are culturally and linguistically relevant to our community:

Respect for Individual Rights: The rights of children and youth will be protected, and effective advocacy efforts for children and youth will be promoted.

Individualization: Services are children and youth and family centered and culturally sensitive, with the unique needs of the youth and family dictating the types and mix of services provided.

Early Intervention: Early identification of social, emotional, physical, and educational needs will be promoted to enhance the likelihood of successful early intervention and lessen the need for more intensive and restrictive services.

Partnership with Youth and Families: Families or surrogate families will be full participants in all aspects of the planning and delivery of services. As children reach maturity, they will be full participants in all aspects of the planning and delivery of services.

Family Strengthening: Family preservation and strengthening, along with the promotion of physical and emotional well-being, is a primary focus of the system of care. Services that require removal of children and youth from their home will be considered only when all other options have been exhausted, and services aimed at returning the children and youth to their family or other permanent placement are an integral consideration at the time of removal.

Access to Comprehensive Array of Services: There will be access to a comprehensive array of services that addresses each child's unique needs.

Community-based Service Delivery: Service availability, management and decision-making rest at the community levels.

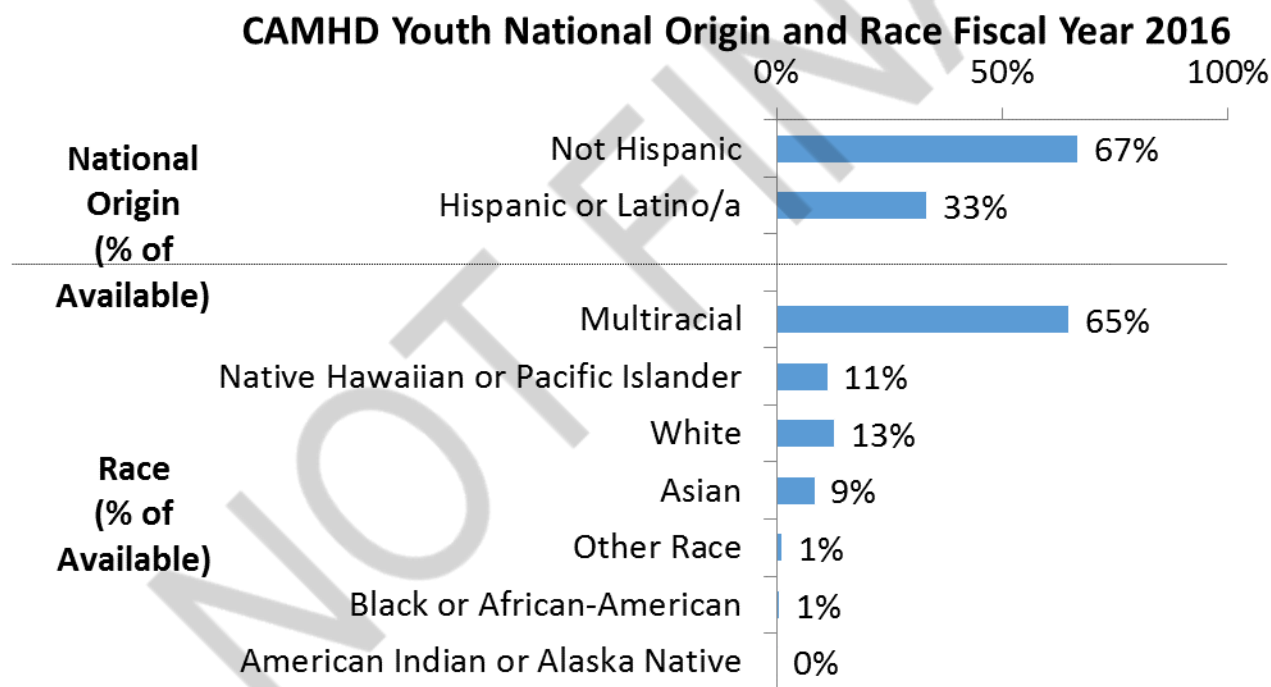
Least Restrictive Interventions: Services will be provided within the least restrictive, most natural environment that is appropriate to individual needs.

Coordination of Services: The system of care will include effective mechanisms to ensure that services are delivered in a coordinated and therapeutic manner, and that children and youth can move throughout the system in accordance with their changing needs, regardless of point of entry.

Culturally Competent Services

CAMHD remains committed to ensuring that all services are provided in a culturally and linguistically competent manner. As a result of the unique and diverse nature of Hawai'i's population, including over ten common non-English language-speaking subgroups, CAMHD staff and administration understand the importance of addressing cultural beliefs and differences and remain fully aware of the ways in which the quality and effectiveness of mental health services are inherently tied to those beliefs and differences. Cultural competency is addressed with all of the providers within the CAMHD network and with all Division staff and administrators through training opportunities in this area as well as the provisions for cultural competence included in relevant policy and procedures, contract management standards, and parental rights brochures. In CAMHD's 2013-2014 Consumer Report, 96.1% of respondents reported the belief that services were culturally sensitive (the highest agreement ratings of all areas measured). CAMHD's registered population is diverse and reflects the characteristics of the general population.

Table 2
Youth Served by Race, FY2016



CAMHD Clinical Model

To ensure appropriate, effective and efficient treatment, CAMHD maintains clinical oversight of each youth served. Each youth is assigned a Mental Health Care Coordinator who will facilitate the planning, coordination of services and monitoring of treatment through consultation with the Branch Clinical Lead.

Clinical Lead. Within each Branch, a Clinical Psychologist and a Child Psychiatrist provide clinical direction to the treatment provided to youth through their collaboration and consultation with the youth's assigned Care Coordinator. Clinical review by a psychologist or psychiatrist helps to assure that

the services authorized are appropriate to address the youth's difficulties and that they meet "medical necessity" criteria. Each youth will be assigned a "Clinical Lead" who will oversee their care and authorize services. The Clinical Lead's involvement may also include consulting with the service provider to help with planning treatment and designing interventions for the youth in order to assure efficient, effective care.

Intensive Case Management

Within 48 hours of registration, youth at CAMHD are assigned a Mental Health Care Coordinator (MHCC) from their regional Family Guidance Center to provide intensive case management. The MHCC serves as the central point of contact for the delivery and coordination of mental health services to youth and the family and ensures that needed services, interventions, and strategies are identified and delivered in a coordinated manner and in partnership with the families.

The MHCC is also responsible for engaging the youth and family, referring the youth for appropriate services, maintaining contact with the youth/family, ensuring the timely and efficient delivery of quality services, and continuously monitoring the effectiveness of interventions. The youth's MHCC is responsible for convening an initial Coordinated Service Plan meeting within 30 days of eligibility determination, or immediately, if the youth has immediate needs and assuring service delivery within 30 days of identification for routine services. When appropriate, responsibilities also include coordination of care with Family Court, the Department of Human Services (child welfare and Medicaid) and other state and community agencies. The MHCC is responsible for facilitating the integration, coordination, and monitoring of behavioral health services across programs and domains and to initiate necessary adjustments to services when needed through the team based process. Parent Partners from the Family Support Organization are also available to provide peer support to parents. Contracts are responsible for coordination of services that are provided within their agency and regular communication about their services to the MHCC.

In order to assure youth-centered, culturally competent and effective services, MHCCs undergo internal training on engagement skills, intensive case management, coordinated service planning process, mental health assessments, Child and Adolescent Functional Assessment Scale (CAFAS), Ohio Scales, and Achenbach tools, evidence-based services and practice elements, and interagency performance standards and practice guidelines.

Table 3
Youth Served by Primary Diagnosis, FY2016

FY2016 Primary Diagnosis (DSM-5)	N	% of Available
Anxiety Disorders	122	6.0%
Bipolar and Related Disorders	35	1.7%
Depressive Disorders	314	15.4%
Disruptive, Impulse-Control, and Conduct Disorders	533	26.1%
Neurodevelopmental Disorders		

Attention-Deficit/Hyperactivity Disorder	398	19.5%
Autism Spectrum Disorder	20	1.0%
Intellectual Disability	6	0.3%
Other Neurodevelopmental Disorders	0	0.0%
Obsessive-Compulsive and Related Disorders	18	0.9%
Schizophrenia Spectrum and Other Psychotic Disorders	37	1.8%
Substance-Related and Addictive Disorders	33	1.6%
Trauma- and Stressor-Related Disorders		
Adjustment Disorder	242	11.9%
Posttraumatic Stress Disorder	182	8.9%
Other Trauma- and Stressor-Related Disorders	27	1.3%
Other Infrequent CAMHD Diagnoses ^a	23	1.1%
General Medical Conditions or Codes No Longer Used	50	2.5%
Not Available	456	18.3%

^aIncludes, but is not limited to, Dissociative Disorders, Elimination Disorders, Feeding & Eating Disorders, Gender Dysphoria, Neurocognitive Disorders, Paraphilic Disorders, Personality Disorders, "Other Mental Disorders," and "Other Conditions That May Be a Focus of Clinical Attention."

Data-Driven

CAMHD's emphasis on data-driven decision making is another strength. Service data is constantly analyzed to both ensure quality and identify needed areas of improvement. This is evident through an extensive library of relevant technical reports ranging from Quality Assurance programs, quarterly Interagency Performance Monitoring and Utilization Management Reports, Annual Fact books, Provider Reports, and Consumer Survey Reports. Data analyzed and presented in these reports have been published in peer-reviewed publications, presented at national conferences and posted online for public consumption. Also, results from these reports are not only presented to CAMHD's various committees via hard copy and/or online, but are often presented to local stakeholders. Stakeholder interpretation of data often results in a different focus and priority, depending on the needs brought to light by the reports.

Health Information Technology

Over the past few years, CAMHD has made considerable progress in the area of Health Information Technology, especially with its implementation of Telehealth services. By providing Telehealth capability at each of the CAMHD's Family Guidance Centers and major providers across the state, CAMHD will be able to increase access to care in remote/shortage areas and increase family contact and family therapy for youth and their families who are physically separated. This will benefit youth in residential placement on one island that have family members living on another. Telehealth will allow the family to

have some contact with the youth and will also provide an opportunity for the family to continue family therapy. The secure Telehealth system adheres to HIPAA privacy requirements. Another goal is to integrate Telehealth functions with Electronic Health Record operations. Not only will operations be more efficient but cost savings will arise from reducing travel costs as well as increase access to professional services from anywhere across the Telehealth network. Training sessions can also be hosted throughout the state using the videoconference system.

Quality Assurance in Clinical Care

CAMHD measures and tracks multiple critical clinical indicators for all clients with regard to client progress. CAMHD administers and monitors the Ohio Scales and CAFAS to measure improvements in client functioning, and tracks and evaluates reasons for discharges. To assure quality in provider services, CAMHD evaluates performance measures such as Client Satisfaction surveys, proportion of PDE utilization (as measured by the MTPS) and service utilization for evidence-based programs such as Multi-Systemic Therapy and Functional Family Therapy. To ensure person-centered care, CAMHD monitors grievances, sentinel events, seclusions and restraints, and number of families served by the Family Support Organization.

At the broader system of care level, as a result of the 1994 Felix Consent Decree, the Department of Education and Department of Health-CAMHD developed an interagency accountability system to monitor, evaluate, and improve the system of care. Around 2002, the Departments of Health and Education began meeting regularly to share information on the performance of their own systems as well as the interface between them. In 2004 the effort was expanded to include additional child-serving agencies into the Interagency Quality Assurance and Accountability System. More recently the group was renamed the Hawaii Interagency State Youth Network of Care (HI-SYNC) and its monthly meetings include representatives from Child Welfare Services, Family Court, Developmental Disabilities Division, Alcohol and Drug Abuse Division, Early Intervention Services, the Children's Coordinating Councils Office, and Hawai'i's statewide family organization. At the local level, district quality assurance teams meet monthly to review data and track improvement activities, while each "shared" child is reviewed at least quarterly. Annual case-based reviews are used to measure child status and system performance. A joint report, Hawaii Youth Interagency Performance Report (HYIPR) has already been issued. Currently, work is in process to formalize the working relationships into a new Memorandum of Understanding among HI-SYNC members.

SERVICES TO ADDRESS THE NEEDS OF DIVERSE POPULATIONS

Services for Lesbian Gay Bisexual Transgender (LGBT)

As a youth-serving organization, the children's mental health division acknowledges that LGBT youth are in various stages of awareness and comfort with their sexual orientation and gender identity. Children's mental health has non-discrimination policies in place regarding Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual, 2 Spirit, *Mahu* and gender non-conforming youth. The policy and practice guidelines establish operational practices that reinforce commitment to respect and dignity to ensure that all people have equal access to all available services, placements, care, treatment and benefits without bias and in a professional and confidential manner. The highest quality of services will be provided regardless of their actual or perceived race, ethnicity, sex, immigration status, disability, national origin, sexual orientation, or gender identity or expression. All reasonable steps within our control will be made to meet the diverse needs of all youth, employees, and contractors and provide an environment in which all individuals are treated with respect and dignity. Employees, volunteers and

contractors use respectful language and terminology that does not further stereotype about LGBT people. Youth are allowed to dress and present themselves in a manner consistent with their gender identity. Grooming rules and restrictions, including rules regarding hair, make-up, shaving, etc. are the same for male and female units. Transgender girls cannot be required to have a male haircut or to wear masculine clothing. Transgender boys shall not be required to maintain a female hairstyle, to wear make-up, or to wear feminine clothing.

CAMHD also established a Safe Spaces Committee – a cohort of staff and community members whose mission is to create and maintain an LGBT-affirming system of care that promotes the use of inclusive language, encourages accepting attitudes, embraces diversity, and provides education to the greater community. The Committee spearheaded several initiatives in an effort to improve CAMHD services and the broader system of care for Lesbian, Gay, Bisexual, and Transgender, Questioning or Queer (LGBTQ) individuals. Accomplishments of the Committee include: 1) draft and champion the passage of Act 181, which changed the age of consent for mental health services from 18 to 14, aligning mental health age of consent with reproductive health services and substance abuse treatment; 2) established a non-discrimination policy for CAMHD; 3) created and distributed affirming, safe spaces posters to all CAMHD Family Guidance Centers; 4) maintains and disseminates an LGBT Youth Resource Brochure – currently assembling a neighbor island version; 5) sponsored CAMHD staff's attendance at the 2015 and 2017 Building Competency in Serving LGBT Youth Conference; 6) presented to the Committee on LGBT Youth in the Juvenile Justice System; and 7) edited CAMHD forms, policies, and procedures to ensure they are LGBT inclusive.

Services for Co-occurring Disorders

Many youth receiving services from CAMHD have mental health disorders that co-occur with substance abuse, intellectual or developmental disabilities, or medical impairments. The presence of co-occurring disorders is assessed with all youth at the point of initial evaluation, as well as routinely during the course of on-going treatment. CAMHD does not provide services that are appropriate for youth with moderate or severe intellectual disabilities or severe autism spectrum disorders. Youth with mild intellectual disabilities and pervasive developmental disorders that are secondary to a diagnosed mental health disorder may be eligible for CAMHD in-home supports and treatment services. CAMHD requires all its providers to provide integrated treatment for co-occurring substance abuse disorders and mental health treatment with appropriate accommodations for youth with medical impairments. Youth with a primary diagnosis of substance abuse can access services from our sister agency, the Alcohol and Drug Abuse Division (ADAD). When necessary, ADAD has capacity available for residential treatment.

Services for Special Populations

CAMHD has 3 SAMHSA system of care grants to address the needs of specific populations.

Kealahou Services (Hawaiian: Navigating Pathways to Healing)

Kealahou Services focuses on improving the lives of girls who have experienced significant trauma. The program collaborates with Hawaii's child-serving agencies, communities and families to help girls build and nurture healthy relationships that will allow them to reconnect with their families, communities and themselves. *Kealahou Services* provides one-on-one support to girls, assists girls in setting and accomplishing personal goals, and offers opportunities for girls to participate in social and cultural group activities that promote connection to family, community and self.

Project Laulima (Hawaiian: Many hands working together)

The purpose of Project *Laulima* is to develop more integrated and comprehensive services to children and youth with co-occurring mental health needs and developmental disabilities. The Developmental Disabilities Division and Child and Adolescent Mental Health Division of the DOH, the Department of Education, the Department of Human Services, and several family and youth organizations are brought together to work on improving collaboration and coordination to meet the multi-agency needs of children and youth with both mental health needs and developmental disabilities. Project *Laulima* focused on the development of new policies and programming, and providing service accountability. To support the work, activities such as community outreach activities, workforce development and comprehensive training initiatives were undertaken. Work from the grant has initiated a new service, Comprehensive Behavioral Intervention. Comprehensive Behavioral Intervention (CBI) is based on basic, well-documented approaches. Since then, over 45 youth have been enrolled.

Kaeru (Japanese: Returning to a point of origin)

Kaeru Services is specifically focused on returning youth from out-of-state residential treatment programs back to their home communities and preventing the future displacement of youth to out-of-state programs when possible. The program will utilize a combination of an intensive care planning process and a clinical intervention model. Implementing *Kaeru* Services will involve strengthening the infrastructure of the Hawai'i child-serving system so that it better exemplifies system of care principles. This will include a better integration of family and youth voice and choice at all levels of the system, increased cultural and linguistic competence, and improved interagency collaboration.

The projected outcomes of this program include the successful return of youth placed in out-of-state placements; the reduction of future placements of youth in out-of-state care; a reduction in the cost resulting from fewer out of state placements; improvement in the delivery of clinical services and improvement in quality of life outcomes.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Step 2. Analysis of Unmet Service Needs and Critical Gaps within the Current System

ADULT MENTAL HEALTH UNMET SERVICE NEEDS AND GAPS

The State's plan and priorities to address unmet needs are addressed through the AMHD's Strategic Plan, 2015-2020, and its tasks are included in the AMHD Work Plans. These areas of concern were consistent with the results of the AMHD Chief's Statewide Roundtable meetings that included consumers, providers, and family members held during 2016-2017.

Unmet needs and critical service gaps across the AMHD System of Care identified were:

- Improve access to quality care in rural and geographically remote areas
- Lack of hospital psychiatric bed availability for non-forensic consumers
- Limited access to transportation to access appointments and employment on the neighbor islands
- Consumers with private insurance don't have access to Clubhouses
- Inconsistent quality of skills and vacancies among workers
- More homeless outreach and homeless shelters for individuals with SMI
- Develop, train, and sustain peer specialists in the workforce
- Need more 24-hour group homes statewide
- Need integrated mental health services
- Strengthen the community mental health centers as a way to address the integration of behavioral health and primary care
- There's a lack of psychosocial rehabilitation services in the community to support consumers
- Lack of local detox facilities
- Lack of crisis services with health care status and 24-hour availability
- Lack of available, affordable respite care
- Need to create funding stream for gaps in care
- Lack of Representative Payee services
- The need for Adult Residential Care Homes (ARCH) for the SMI population
- The need for a Skilled Nursing Facility

The AMHD will address most service gaps based on prioritization and availability of general funds or Mental Health Block Grant funds in 2018-2019:

Crisis Services

- The State is looking into Urgent care for immediate follow-up, where there are up to three therapy sessions, full psychiatric work-up, medications/prescriptions and referrals for additional follow-up. This services will be located within a Crisis Triage Center or Crisis Stabilization Unit.
- Mental Health Emergency workers will be replicated for Hawaii, Kauai, and Maui counties. The basic framework for these emergency workers will be built into a Crisis Services contract.
- Since there are no crisis beds on Kauai, the development of a "Crisis Respite" model for individuals who need crisis services and who might be eligible for a Licensed Crisis Residential Services is being entertained.

Case Management and Community Support/Treatment Services

- The Community Based Case Management service (CBCM) contracts are proposed to be changed to a maximum 1:24 staff to consumer ratio, versus the current maximum 1:30 ratio.

- The need for increased units of service (case management hours) is being addressed by requiring providers to track and report consumer acuity levels in order to justify increased case management units/hours.
- The AMHD plans to offer additional Representative Payee Services.
- A pool of qualified professionals has been expanded to include Advanced Practice Registered Nurse with prescriptive authority (APRN-Rx) to work in rural areas.
- The AMHD plans to allocate more CBCM slots in Kauai County.
- The Maui branch of AMHD is trying to hire a third staff person to serve consumers. This individual will be able to provide additional homeless outreach as well as CBCM services.

Community Housing Services

- Implementation of new housing admission and continuing stay criteria will create movement of consumers through the service array toward more independent long term community housing.
- Re-visit long term strategy to ensure adequate movement of consumers through AMHD's housing continuum.
- Decrease lengths of stay in 24-hour group homes statewide, and encourage greater movement to least restrictive and non-AMHD funded housing.
- Improve AMHD's management of housing resources and promote increased presence in 24-hour group homes via on-site chart reviews and discharge planning.
- Develop tools/processes necessary to more accurately track current vacancies in 24-hour group homes as well as to assist providers with maintaining candidate waitlists which are reflective of AMHD priorities.

Psychosocial Rehabilitation Services

- Psychosocial rehabilitation programming will continue to be included in all case management contracts to increase rehabilitative capacity statewide.
- The Department of Health has placed hiring Clubhouse staff as a major priority for continuous recruitment and emergency hire.
- Efforts are underway to improve workforce development for current staff.
- Hire stable staffing that can develop jobs and provide job coaching skills to Clubhouse members, as well as, staff who are willing to work flexible hours to accommodate holidays and weekend hours.
- Look into refurbishing or purchase an apartment building for Clubhouse members on Hawaii County.

Expanded-ARCH Program

- The State is actively working towards building a 50-bed Skilled Nursing Facility.
- In response to Hawaii's growing older adult population and co-morbidity of serious/chronic medical needs of the population, AMHD is working to offer Adult Residential Care Homes, who are specifically trained and mentored to address the needs of the fragile and/or elderly individuals with SMI.

Further, the AMHD uses reliable sources to monitor data and inform decision-making. The Uniform Reporting System (URS), the SAMHSA Mental Health Statistics Improvement Program (MHSIP), the Quality of Life Assessment results, and the Behavior Health Barometer are used to identify needs and gaps in services, as well as to measure progress for Hawaii's adult population.

Based on the unmet needs and critical service gaps, the AMHD made the following goals as the priorities to address the unmet needs at the local, county and state levels. The priorities therefore are:

- To reduce fragmentation of services for consumers within the AMHD system of care.
- To establish population-based services to promote recovery, resiliency and positive outcomes for individuals living with mental illness.
- To attract, recruit, and retain a competent, credentialed workforce.
- To increase the engagement of consumers and access to services across systems for adults with SMI.

CHILDREN'S MENTAL HEALTH UNMET SERVICE NEEDS AND GAPS

Two years ago, while conducting a needs assessment and environmental scan for its strategic plan, the Child and Adolescent Mental Health Division identified unmet needs and critical service gaps. Although CAMHD has made progress and achieved accomplishments on the Strategic Plan, gaps and need remain. For the upcoming block grant period, the Child and Adolescent Mental Health Division (CAMHD) will work on the following priorities.

- Address the mental health needs of homeless youth
- Sustain and expand trauma-informed mental health care
- Increase access to care in rural areas, including the Neighbor Islands
- Establish population-based data to identify critical gaps and needs
- Expand on interagency partnerships and collaborations within the system of care

Homelessness

Despite the picturesque setting, and perhaps because of it, Hawaii is home to many people without a permanent residence. The cost of living and the cost of housing are among the highest in the nation. As wealthy people from across the ocean purchase luxury second and vacation homes, the locals are priced out of the housing market. One of the hardest hit ethnic groups is Native Hawaiians. Many Native Hawaiians have resorted to living in cars and beaches, taking their families with them. Children are exposed to instability and insecurity, which can create mental distress.

According to the Children's Defense Fund (Children in the States – Hawaii, September 2015):

- More than 2,312 Hawaii public school students were homeless in the 2012-2013 school year.
- In 2014, more than 4 full-time minimum-wage jobs were necessary to be able to afford a fair market two-bedroom rental apartment in Hawaii and still have enough left over for food, utilities and other necessities.
- More than 22 percent of children lived in households that lacked access to adequate food in 2013.
- Nearly 24 percent of Hawaii children relied on the Supplemental Nutrition Assistance Program (SNAP) to meet their nutritional needs on an average month in FY2013.
- Nearly 91 percent of Hawaii children receiving a free and reduced-price lunch during the school year did not participate in Summer Nutrition Programs in 2014 – ranking Hawaii 44th of 50 states in ensuring that children have adequate summer nutrition.

Trauma-informed Services

Now that CAMHD has learned lessons from its system of care Project Kealahou, there is a need to maintain and sustain those hard-won treatments and strategies for girls with histories of trauma. Kealahou Services are evidence-based services that address a previous gap in Hawaii's mental health

services. These services are the first set of services and strategies designed to address the internalizing behaviors typical of females.

Workforce Shortages, particularly in rural areas

There has been a long-standing shortage in clinical leadership and expertise for children's mental health on the east side of Hawaii. The Clinical Director position has been vacant for over 3 years. Issues such as poverty, geographic isolation, cultural differences, limited availability of providers, and other barriers prevent the engagement and retention of clients. The Child & Adolescent Mental Health Division has had to be creative in filling that gap with telepsychiatry, air travel, and use of ZOOM to hold clinical supervision meetings across islands.

Data and Information Systems

At this time, the Department of Health, Behavioral Health Administration, lacks sufficient capacity to assemble demographic, outcomes, and other data to assess the needs, services and outcomes of behavioral health clients across all of the Behavioral Health Administration. Data is needed to analyze the effectiveness of programs and needs of the larger community. The vision is that when gaps are identified, services will be instituted to address them. Having timely data can improve clinical outcomes and reduce costly delays. Limited resources can be utilized in a more efficient manner, and youth will no longer get "lost" or "fall through the gaps" of the system.

Sustaining System of Care Partnerships

The Hawaii Interagency State Youth Network of Care (HI-SYNC) collaborative partnership of child-serving agencies is an active and effective body, but there is no staff to help coordinate meetings and initiatives. All the agencies are committed to this collaborative partnership, but they have identified the need for staff to help facilitate its work. The monthly meetings include representatives from Child Welfare Services, Family Court, Developmental Disabilities Division, Alcohol and Drug Abuse Division, Early Intervention Services, the Children's Coordinating Councils Office, and Hawai'i's statewide family organization, and it is a task to get those meetings on everyone's calendars. In addition to the state level meetings, meetings must be coordinated at the local levels with all the relevant parties for the system to be effective. The effort would benefit from having staff to coordinate and support those activities.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Community-Based Services
Priority Type: MHS
Population(s): SMI

Goal of the priority area:

Increase access to mental health services

Objective:

To provide mental health services that individuals find accessible.

Strategies to attain the objective:

Monitor the number of consumers served in the Adult Mental Health system of care, compared to the prevalence of adults with serious mental illness in Hawaii.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number/percent of adults receiving AMHD services.
Baseline Measurement: Unduplicated number/percent of consumers served by AMHD by age, gender, race/ethnicity, and by county. The baseline measure is 7,647 based on the FY2016 data.
First-year target/outcome measurement: Increase the number served by 5%.
Second-year target/outcome measurement: Increase the number served by 10%.

Data Source:

Census data for Hawaii
NRI Uniform Reporting Service Tables

Description of Data:

Monitoring the treated prevalence rates indicates improved ability to identify consumers and provides a general measure of access to track longitudinal data.

Data issues/caveats that affect outcome measures::

Data error.

Priority #: 2
Priority Area: Homeless Intensive Case Management Program
Priority Type: MHS
Population(s): SMI

Goal of the priority area:

To decrease the incidence of arrests and hospitalizations for homeless individuals with a serious mental health condition, and to provide linkages to continuing supports.

Objective:

The Intensive Case Management team will provide supportive services 24 hours/days, 7 days/week through rapid response to emergent needs, assisting consumers in resolving crisis in the least restrictive setting and preventing the need for more intensive interventions.

Strategies to attain the objective:

- Decrease the rate of admissions to the system.
- Decrease the rate of hospitalization and arrests.
- Increase the number of permanent housing placements.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of homeless individuals with arrests and hospitalizations.

Baseline Measurement: Ensure homeless individuals have no arrests, emergency room visits and are placed in shelters or temporary to permanent housing.

First-year target/outcome measurement: Decrease the number of arrests and hospitalizations by 50%.

Second-year target/outcome measurement: Decrease the number of arrests and hospitalizations by 75%.

Data Source:

Electronic Health Records
Homeless Management Information System

Description of Data:

Total number of individuals identified as homeless
Total number of homeless individuals with mental health or substance use issues
Total number of homeless individuals with re-arrests
Total number of homeless individuals with hospitalizations
Total number of homeless individuals placed in permanent housing

Data issues/caveats that affect outcome measures::

Identified consumers refuse to participate in the program.

Priority #: 3

Priority Area: Hawaii Certified Peer Specialist

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To train individuals with lived experiences of mental illness to model recovery skills for their peers.

Objective:

Increase the number of Hawaii Certified Peer Specialists (HCPS) in Hawaii, and to increase the number of employed HCPS.

Strategies to attain the objective:

To offer an annual training with no out-of-pocket expenses; identify service providers who will employ the HCPS; and to work towards filling HCPS in their service structure.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of Certified Peer Specialists in Hawaii

Baseline Measurement: As of July 2017, there are 35 HCPS individuals who are currently working. The goal is to increase that number

First-year target/outcome measurement: Increase the number of Certified Peer Specialists in Hawaii by 10%.

Second-year target/outcome measurement: Increase the number of Certified Peer Specialists who are gainfully employed by 10%.

Data Source:

Certified Peer Specialists examination data sheets.

Description of Data:

Tracking of CEU's

Data issues/caveats that affect outcome measures::

Loss of HCPS numbers due to the negative impact to ones disability benefits.

Priority #: 4

Priority Area: Social Security Benefits

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase access to SSI/SSDI Outreach, Access and Recovery (SOAR) income benefits.

Objective:

To increase the number of homeless individuals enrolled in the SOAR program.

Strategies to attain the objective:

- Mandatory for all homeless outreach workers to be certified in SOAR.
- Once staff is certified, they must submit at least two SSI/SSDI applications per month for processing.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of homeless individuals to obtain SSI/SSDI benefits.

Baseline Measurement: Each application submitted by case managers will be approved by the Social Security Administration.

First-year target/outcome measurement: 50% of all applications will be approved.

Second-year target/outcome measurement: 75% of all applications will be approved.

Data Source:

The SOAR online Application Tracking (OAT) system, which shows the progress and approval of applications.

Description of Data:

Data issues/caveats that affect outcome measures::

Case managers forgetting to input information into the OATs program

Priority #: 5

Priority Area: To fund those priority treatment and support services not covered by Medicaid, Medicare or other private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase access to mental health treatment and support services to homeless youth and their families.

Objective:

Provide mental health treatment and support services to 100 homeless youth.

Strategies to attain the objective:

Provide outreach to and services for homeless children and their families.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of homeless children provided mental health services

Baseline Measurement: 100 homeless children and their families

First-year target/outcome measurement: 100 homeless children and their families will be identified and provided mental health services

Second-year target/outcome measurement: 100 homeless children and their families will be identified and provided mental health services

Data Source:

Catholic Charities Homeless Mental Health Supports annual program report.

Description of Data:

Number of children identified by the MTHP staff or through outreach or other partner agencies

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: To provide evidence-based practices for early intervention to address Early Serious Mental Illness

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

To increase access to evidence-based services for early intervention of serious mental illness

Objective:

To provide evidence-based services to 16 youth and young adults with First Episode Psychosis

Strategies to attain the objective:

To provide evidence-based services for early intervention of First Episode Psychosis

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth and young adults provided services in the First Episode Psychosis program

Baseline Measurement: 16 youth and young adults with First Episode Psychosis

First-year target/outcome measurement: 16 youth and young adults with First Episode Psychosis provided evidence-based early intervention

Second-year target/outcome measurement: 16 youth and young adults with First Episode Psychosis provided evidence-based early intervention

Data Source:

University of Hawaii, OnTrack Hawaii annual reports

Description of Data:

Number of youth and young adults with First Episode Psychosis who are enrolled in the program and received services.

Data issues/caveats that affect outcome measures::

Footnotes:

NOT FINAL

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention		\$0	\$0	\$300,000	\$150,000	\$0	\$0
a. Substance Abuse Primary Prevention							
b. Mental Health Primary			\$0	\$300,000	\$150,000	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		\$305,539	\$0	\$0	\$0	\$0	\$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			\$0	\$0	\$61,910,275	\$0	\$0
7. Other 24 Hour Care		\$100,000	\$7,000,000	\$0	\$49,487,892	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$1,467,772	\$1,000,000	\$500,000	\$55,955,774	\$0	\$0
9. Administration (Excluding Program and Provider Level)		\$333,379	\$1,500,000	\$1,438,629	\$22,069,164	\$0	\$0
10. SubTotal (1,2,3,4,9)	\$0	\$333,379	\$1,500,000	\$1,738,629	\$22,219,164	\$0	\$0
11. SubTotal (5,6,7,8)	\$0	\$1,873,311	\$8,000,000	\$500,000	\$167,353,941	\$0	\$0
12. Total	\$0	\$2,206,690	\$9,500,000	\$2,238,629	\$189,573,105	\$0	\$0

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMH or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

10. Subtotal (1,2,3,4,9) totals \$638,918

11. Subtotal (5,6,7,8) totals \$1,567,772

NOT FINAL

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	\$265,000			
2. Infrastructure Support	\$27,000			
3. Partnerships, community outreach, and needs assessment	\$261,203			
4. Planning Council Activities (MHBG required, SABG optional)	\$30,000			
5. Quality Assurance and Improvement	\$40,000			
6. Research and Evaluation	\$30,000			
7. Training and Education	\$25,000			
8. Total	\$678,203	\$0	\$0	\$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁵ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁶ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁷

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.²⁸ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁹ For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.³⁰

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³¹ SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³² The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.³³ Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁴ and ACOs³⁵ may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³⁶ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁷

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁸ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁹ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.⁴⁰ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.⁴¹ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴² Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁴³ SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴⁴ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

²⁵ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102?123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52?77

²⁶ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁷ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁸ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

²⁹ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

³⁰ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

³¹ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

³² Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

- ³³ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>
- ³⁴ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>
- ³⁵ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx
- ³⁶ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>
- ³⁷ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>
- ³⁸ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>
- ³⁹ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>
- ⁴⁰ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. *Health Affairs*, 2014; 33(4): 700-707
- ⁴¹ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, *JAMA Psychiatry*, 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, *JAMA Psychiatry*, 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. *JAMA Psychiatry*, 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. *Annals of Emergency Medicine*, 2011; 58(2): 218
- ⁴² Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. *Health Affairs*, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>
- ⁴³ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>
- ⁴⁴ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

At the adult level, the integrated primary and behavioral health care "Living Well Hawaii" project serves Hawaii's residents with serious mental illness (SMI) who receive healthcare services from the state-operated West Honolulu Treatment Services Section and the Central/Leeward Oahu Treatment Services Section in collaboration with the Kalihi-Palama Health Center (KPHC), a private, non-profit, Federally Qualified Health Centers (FQHC). The goal of the Living Well Hawai'i Project is to improve the physical health status of people with SMI and comorbid, chronic medical conditions. It is expected, based upon past research and evaluation efforts that providing access to culturally competent, integrated, comprehensive, collaborative care will substantially improve the quality and health outcomes of care for these services. The project is jointly funded by the State of Hawaii Department of Health (DOH) and a four (4) year federal Substance Abuse and Mental Health Services Administration grant awarded to the DOH, AMHD.

The Living Well Hawaii Project employs an enrollment process to prioritize and actively recruits consumers who meet any of the following criteria: 1) no assigned PCP, 2) actively use tobacco, and 3) diagnosed with hypertension, hyperlipidemia, diabetes, and/or obesity. Consumers who meet any one of these criteria are asked by members of their treatment team to participate in the project. Consumers who agree to participate in the project receive a comprehensive medical evaluation by the project's primary care provider. The primary care provider is responsible for providing both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis. The primary care providers may be a physician, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law.

The Treatment Services Sections utilize standardized tools and adhere to timeframes and report guidelines from the point of enrollment until discharge. The integrated treatment team is comprised of the consumer, the primary care providers and the behavioral health service providers to work with individuals with co-occurring mental and substance use disorders. The case manager is responsible for supporting the work of the primary care provider by performing routine tasks and procedures such as

measuring the consumer's vital signs, administering medications, and injections, recording information in medical record keeping systems, preparing and handling medical instruments and supplies, collecting and preparing specimens of bodily fluids and tissues for laboratory testing and triaging the enrolled consumer's primary healthcare needs in the absence of a primary care provider. The Integrated Treatment Team is the primary healthcare and behavioral healthcare team members responsible for collaboratively assisting the enrolled consumer in developing a plan of care for successfully achieving specific physical and behavioral health outcomes through a shared treatment team approach.

Although the Living Well Project is still in its infancy stage, the Hawaii Health Families and Healthy Communities initiatives through the Round Two State Innovation Model (SIM) Design Award to improve behavioral health for adults and children is working to strengthen the health care delivery system to support behavioral health integration. The DOH and the Department of Human Services (DHS) are partners in SIM efforts, which are supported by a grant to the Governor's Office. Hawaii's SIM focus through its State Health Innovation Plan is to increase access to behavioral health services and reduce barriers for populations with health disparities.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

In August 2014, nearly all Medicaid beneficiaries were enrolled in some form of managed care when it implemented the QUEST Integration program, which covers acute, primary, and behavioral health care services for children and adults. Individuals have a choice to select medical plan from five participating health plans: AlohaCare, Hawaii Medical Services Association, Kaiser Foundation Health Plan, 'Ohana Health Plan and United Healthcare Community Plan. As of April 2016, there has been a 96 percent increase in Medicaid enrollment.

To reduce fragmentation of services for individuals with serious mental illness and substance use disorders, the DOH and the DHS have consolidated their behavioral health services provisions within the Comprehensive Community Services (CCS) program. The Medicaid contractor for CCS is 'Ohana Health Plan. The CCS program is a recovery focused, integrated behavioral health program that provides community based integrated services for individuals of all ages who need ongoing services for a mental illness and substance use disorder beyond outpatient care, but less than the intensive care provided in an inpatient setting. CCS provides a coordinated and comprehensive array of recovery services, treatment, and psychosocial rehabilitation services such as, representative payee, supported employment and supported housing. Further, Hawaii has shifted in the integrated system of care from pay-for-performance (volume), to pay-for-quality (outcomes). Reimbursement is increasingly tied to quality metrics and patient outcomes.

While Hawaii has made progress towards integrated care, such services are not offered consistently or uniformly. For instance, there are administrative barriers preventing full integration of the Hawaii's Alcohol and Drug Abuse and the AMHD, as well as, among programs and individual providers of substance use and mental health services. The current system of care is fragmented with the need to integrate substance use and mental health treatment. Thus, individuals with co-occurring disorders and concerns often "fall through the cracks." An explanation of this is that both divisions have separate contracting and financial systems and there are limitations for integration due to inconsistent policies in State statutes governing substance use programs, state barriers such as rules, funding guidelines, as well as, the lack of local control of funding, and program planning.

Many youth receiving services from the Child and Adolescent Mental Health Division (CAMHD) have mental health disorders that co-occur with substance abuse, mild intellectual impairments, secondary diagnoses of developmental disorders, or medical impairments (e.g. blindness, deafness, diabetes, etc.) The presence of co-occurring disorders is assessed with all youth at the point of initial assessment, as well as routinely during the course of ongoing treatment. Youth with mild intellectual disabilities and pervasive developmental disorders that are secondary to a diagnosed mental health disorder may be eligible for CAMHD in-home supports and treatment services. All contractors are required to provide integrated treatment for co-occurring substance abuse disorders and mental health treatment with appropriate accommodations for youth with medical impairments. These services are funded through State dollars.

Through a federally supported system of care grant, Project Laulima (many hands working together) was designed to develop more integrated and comprehensive services to children and youth with co-occurring mental health needs and developmental disabilities. The grant works to improve access and service quality. Project Laulima brings together the Developmental Disabilities Division and CAMHD of the DOH, the Department of Education, the DHS and several family and youth organizations to improve collaboration and coordination to meet the multi-agency needs of children and youth with both mental health needs and developmental disabilities. Project Laulima focuses on the development of new policies and programming, and providing service accountability.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?
and Medicaid?

☐ Yes ☐ No

☐ Yes ☐ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

The state Medicaid agency, Department of Human Services, MedQuest Division, monitors access to mental health and substance abuse services.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? j n Yes j n No
6. Do the behavioral health providers screen and refer for:
- a) Prevention and wellness education j n Yes j n No
- b) Health risks such as
- i) heart disease j n Yes j n No
- ii) hypertension j n Yes j n No
- viii) high cholesterol j n Yes j n No
- ix) diabetes j n Yes j n No
- c) Recovery supports j n Yes j n No
7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? j n Yes j n No
8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? j n Yes j n No
9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

HAWAII'S PARITY EFFORTS FOR BEHAVIORAL HEALTH

The disparity between mental health and medical insurance coverage had been narrowed as the state of Hawaii enacted laws requiring coverage of mental health and substance abuse treatment in the same way as medical and surgical care. In 1999, the Hawaii Legislature established parity in coverage for serious mental illness, treatment of other mental disorders and substance abuse. Under the Hawaii Parity Law, the proportion of deductibles and copayments were not greater than those applied to physical illnesses. Basic mental illness and substance abuse coverage required not less than 30 days of in-hospital services, and not less than 30 visits per year to a physician, psychologist, clinical social worker, or advanced practice registered nurse in hospital, non-hospital or mental health outpatient facilities for day treatment of partial hospitalization services. The total covered outpatient service for substance abuse and mental illness is not less than 24 visits annually.

During the 2003 Legislative Session, the legislators considered expanding the definition of serious mental illness under Senate Bill 1321 to include: delusional disorder, major depression, obsessive compulsive disorder, dissociative disorder, and bipolar disorder. The bill, if enacted, would have meant expanded treatment benefits for these disorders. Finally at the end of the session, the final Senate version of the Bill re-designed bipolar mood disorder as bipolar types I and II, without the expanded definition of serious mental illness. This then became law as Act 197 on June 24, 2003. Later, on June 30, 2011, Chapter 431M of the Hawaii Revised Statutes, parity treatment for alcohol or drug dependency was repealed. Throughout the years, Hawaii has been trying to restore state laws related to behavioral health parity, but has not been successful.

ISSUES RELATED TO IMPLEMENTATION OF INTEGRATION

While Hawaii's health care providers are supportive of parity, barriers exist that prevent the smooth flowing provision of behavioral health.

Through CAMHD's pilot primary care integration initiatives, our experience is that there exist widespread resource shortages throughout the state. There is a shortage in mental health personnel, including psychiatrists, child psychiatrists, clinical psychologists, clinical social workers and APRN-RXs in mental health. The shortages are even more acute for the pediatric population.

Additionally, we have found that Federally Qualified Health Centers (FQHC) are hard-pressed to find time during a patient visit to conduct a mental health screening or provide intervention or seek mental health consultation. While the FQHCs understand the importance of mental health services, the number of hours in a day is limited.

One of the goals of CAMHD's integration projects was to develop models of financing. However, the cessation of the projects did not allow enough time for our initiatives to realize the innovative payment and financing strategies that had been planned.

An area of success was the learning collaborative. The community-based health care professionals already recognized the need for improved coordination of care and integration of physical and behavioral health. The primary care providers were eager and active participants in learning about behavioral health issues. Based on the FQHC's requests for information on specific diagnoses and conditions, we coordinated educational sessions, which were well attended by both primary and behavioral health providers.

10. Does the state have any activities related to this section that you would like to highlight?

None at this time.

Please indicate areas of technical assistance needed related to this section

Technical assistance is not needed at this time.

Footnotes:

NOT FINAL

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴⁵, [Healthy People, 2020](#)⁴⁶, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁷, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)⁴⁸.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁴⁹

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁵⁰. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations⁵¹. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

⁴⁵ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴⁶ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁷ <http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁴⁸ <http://www.thinkculturalhealth.hhs.gov>

⁴⁹ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁰ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵¹ http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?
 - a) Race ☐ Yes ☒ No
 - b) Ethnicity ☐ Yes ☒ No
 - c) Gender ☐ Yes ☒ No
 - d) Sexual orientation ☐ Yes ☒ No
 - e) Gender identity ☐ Yes ☒ No
 - f) Age ☐ Yes ☒ No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ☐ Yes ☒ No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ☐ Yes ☒ No
4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ☐ Yes ☒ No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) standard? ☐ Yes ☒ No
6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? ☐ Yes ☒ No
7. Does the state have any activities related to this section that you would like to highlight?
None at this time.
Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, ($V = Q ? C$)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁵², The New Freedom Commission on Mental Health⁵³, the IOM⁵⁴, and the NQF⁵⁵. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁵⁶ SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series ([TIPS](#))⁵⁷ are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation ([KIT](#))⁵⁸ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

⁵² United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁵³ The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁵⁴ Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁵⁵ National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵⁶ <http://psychiatryonline.org/>

⁵⁷ <http://store.samhsa.gov>

⁵⁸ <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? j n Yes j n No
2. Which value based purchasing strategies do you use in your state (check all that apply):
 - a) ☒ Leadership support, including investment of human and financial resources.
 - b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c) ☐ Use of financial and non-financial incentives for providers or consumers.
 - d) ☒ Provider involvement in planning value-based purchasing.
 - e) ☐ Use of accurate and reliable measures of quality in payment arrangements.
 - f) ☒ Quality measures focus on consumer outcomes rather than care processes.
 - g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
 - h) ☒ The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

The State has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode ([RAISE](#)) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? jn Yes jn No
2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? jn Yes jn No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

OnTrack Hawai'i clinic was established as a full-fidelity Coordinated Specialty Care (CSC) clinic. The clinic is a collaboration with the Child and Adolescent Mental Health Division, the Adult Mental Health Division, University of Hawaii, Department of Psychology, and Hawaii John A. Burns School of Medicine Department of Psychiatry. The clinic provides services to youth and young adults with first episode psychosis.

OnTrack Hawaii clinic has five clinicians trained in coordinated specialty care principles and the Recovery After an Initial Schizophrenia Episode early treatment program. The clinic provides all components of a CSC treatment approach that include case management, individual or group psychotherapy, supported employment and education services, family education and support, and medication management.

Case management is provided by the client's lead therapist. This clinician coordinates the individual's needs that may include advising on an individualized education program, securing employment and medical care. Having a lead therapist designated for each client ensures the multidisciplinary team is collaborating effectively to meet the client needs. Individual therapy for clients varies and is personalized to meet the goals of each client. The individual therapy focuses on resiliency training, symptom coping skills and goals. Supported education and employment emphasize minimizing academic and employment disruptions as well as facilitate employment placement and academic success. Family education and support focuses on giving the client's care givers the tools and understanding what psychosis is and the treatment options available. Their understanding and participation enables them to help with the client's recovery. The last component of the services is medication management which uses a shared decision-based approach using medication intervention. The client, and care giver if applicable, is educated on medication and monitored to ensure medication

compliance and monitoring of side effects. Coordination with primary care provider is ensured to address any potential risks.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Through OnTrack Hawaii clinic client's experiencing first episode psychosis are provided with specialized supported services specifically tailored to address FEP through an evidence based multidisciplinary team approach. The clinic has adopted the RAISE Early Treatment Program principles which incorporates the coordinated specialty care model. Each individual client is supported by a team of trained clinicians in evidence-based treatment for FEP. This team coordinates medication, counseling, social skills training and family education. All services are tailored to support each client's unique needs for recovery.

Treatment plans are developed by employing the concepts of shared decision making and person-centered care. This allows for the client to be a part of developing their comprehensive treatment plan that includes monitoring their care to ensure that their needs are being met. A person experiencing a first episode of psychosis can often be at risk of developing other problems such as substance use, unwanted weight gain, hypertension or increase in suicidal thoughts. In order to effectively monitor these possible risks and treat them, the clinic ensures that a care provider is established for all clients. Care is coordinated with the primary care physician to ensure that medication side effects are monitored and any side effects are appropriately addressed.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? ☒ Yes ☒ No

5. Does the state collect data specifically related to ESMI? ☒ Yes ☒ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ☒ Yes ☒ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

This year the clinic will relocate to a larger space to accommodate all of the clinicians under one roof. The new space will accommodate growth as referrals increase as well as facilitate a more streamlined scheduling process. The location of the new clinic is centrally located, provides free client parking and is on a major public transportation route making it easier for clients to access the clinic services. Other auxiliary care services such as labs, pharmacy and primary care physicians are also located in the same building which will facilitate coordination of those services and give the feel of a one stop shop clinic for clients.

In conjunction with opening a new clinic space OnTrack HI will be launching a recruitment campaign with a focus on access to care. The campaign will provide visibility to the clinic and community awareness of our services. The marketing campaign will employ a combination of professional outreach and public education of psychosis via social media. This will generate direct referrals allowing for faster and better access to our clinic services. Business relationships will also be formalized in forms of letters of support and memoranda of agreement to build collaborations with other community social service agencies, education providers and medical care providers.

An electronic health record (EHR) system is being implemented. The system will facilitate more efficient data capturing and client outcome monitoring to ensure program fidelity. It will also provide better integration of providers by improving information sharing.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

In FFY 2018 a major goal will be to develop a plan to expand access of services to the neighbor islands in Hawaii. In order to accomplish this, the appropriate method of expanding access must first be determined through exploring the unique needs and challenges that providers in the neighbor islands face. We will also need to identify providers that are willing and able to deliver coordinated specialty care for psychosis clients. Some possible options to explore could be by developing a training program for care providers that will give them the tools to provide high fidelity coordinated specialty care. Another option to consider would be to use technology already used in telepsychiatry to provide access to OnTrack HI services.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Data is collected through various assessment scales and monthly reports. The first data collection priority is to collect data on CSC clients that can be compared to treatment as usual for clients enrolled in CAMHD but not in the CSC clinic. All providers in the CAMHD system complete a monthly report called the Monthly Treatment Progress Summary (MTPS). The MTPS documents the type and frequency of services, treatment targets, and treatment interventions used. These data will allow us to demonstrate the impact of the initiative by documenting the services that are provided as part of the clinic.

All clients in the CAMHD system are also rated on the Child and Adolescent Functional Assessment Scale (CAFAS). The CAFAS includes subscales for Role Performance: School/Work, Role Performance: Home, Role Performance: Community, Behavior towards Others, Moods/Self-Harm: Moods/Emotions, Moods/Self-Harm: Self-Harm Behavior, Substance Use and Thinking. Finally, all clients in CAMHD complete the Ohio Scales, which measure problem severity, functioning, and satisfaction with treatment. The parent and youth version of the scales will be used in the clinic. The benefit of using the Ohio Scales to measure problem severity and function is that it will make it easier to compare outcomes from the CSC clinic to other clients in CAMHD.

In addition to measures completed as comparison to other CAMHD clients, clients will complete several other assessments to monitor their treatment progress. First, clients' cognitive functioning will be measured with the MATRICS Consensus Cognitive Battery (MCCB). The MCCB is intended to provide a relatively brief evaluation of key cognitive domains relevant to schizophrenia and related disorders. The MCCB was designed to address the following purposes: an outcome measure for clinical trials of cognition-enhancing drugs for schizophrenia, an outcome measure for studies of cognitive remediation, a measure of cognitive change in repeated testing applications, and a cognitive reference point for non-intervention studies of schizophrenia and related disorders. The MCCB will be given to clients at the beginning of treatment and repeated every six months throughout treatment. The MCCB has alternate forms for repeated administrations.

Symptoms will be rated monthly with the Colorado Symptom Scale, which will be especially important for medication management. However, following the general principles of the RAISE project, the primary outcome goals for CSC clients will be social and role functioning, as measured by the Global Assessment of Functioning scales, and client goals derived from the shared decision making process.

The clinic director will present quarterly reports on these outcome measures to the CAMHD and AMHD administration, including the CAMHD Planner. In addition, the clinic director is an active researcher focusing on the assessment and treatment of early psychosis. The outcome data will be reported in a manuscript that will be submitted for publication in a peer reviewed journal such as Schizophrenia Bulletin or Schizophrenia Research.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Inclusion criteria for care from the OnTrack Hawaii clinic is a diagnosis of Schizophrenia, Schizoaffective Disorder, or Schizophreniform Disorder. Clients may be admitted to the program with other specified schizophrenia spectrum disorder and other psychotic disorder or unspecified schizophrenia spectrum disorder if deemed appropriate by the OnTrack director. However, clients with other specific schizophrenia spectrum disorder, attenuated psychosis syndrome, are not eligible for the program as mandated by the Substance Abuse and Mental Health Services Administration.

Does the state have any activities related to this section that you would like to highlight?

None at this time.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? ☒ Yes ☐ No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
N/A

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
At the adult level, at a minimum, the treatment team for adults is composed of the consumer, prescribing clinician and case manager. The consumer is encouraged to actively participate in the planning, prioritization, implementation and evaluation of the services offered. As much as possible, the plan focuses on the strengths, needs and preferences of the consumer, thus a person-centered approach is used when developing and updating the Individual Service Plan (ISP). The consumer can communicate this information to the team in several ways, which include but not limited to – face to face, telehealth, and/or in writing. The consumer is an essential member of the team and is present at his or her team meetings, and is encouraged to participate actively. With the consent of the consumer, supplementary support members (i.e. family, neighbors, and friends), and/or agencies are invited to the treatment plan meetings. The person-centered plan includes the following components:

- Identification of the needs/desires of the person served through:
 - Goals that are expressed in the words of the person served
 - Clinical goals that are understandable to the person served
 - Goals that are reflective of the informed choice of the person served
 - Statements describing the nature of the specific problems and needs of the consumer are addressed

- Specific service or treatment objectives are:
 - Reflective of the expectation of the person served
 - Reflective of the person's age, development, culture and ethnicity
 - Responsive to the person's disability
 - Understandable to the person served
 - Measurable, achievable, time specific and appropriate to the service or treatment setting.

When the person-centered assessment identifies a potential risk of suicide, violence, or other risky behaviors, a safety plan is enacted. The plan includes:

- Triggers
- Current coping skills
- Warning signs
- Actions to be taken
- Preferred interventions
- Advance Directives, if one is available.

For youth, the process is an individualized and ongoing process that is youth-guided and family/guardian centered. Mental health service planning supports the use of medically necessary evidence-based interventions in the least restrictive environment. As the youth transitions toward adulthood, the goals of the planning revolve primarily around increasing independence. Strategies are included to address the following domains:

- Living arrangement/personal management
- Vocational/education
- Mental health and medical
- Community/social experiences

- Financial support, and
- Employment

For youth, a personal Safety Plan is developed in collaboration with the youth and details his/her preferences for handling potential crises. The Crisis Plan documents the youth's problematic behaviors, setting events, triggers, the youth's preferred methods of calming and regaining control, and the steps his/her caregivers will take in the event that behaviors begin to escalate out of control. The Crisis Plan builds on available information about the youth and the youth's personal Safety Plan.

4. Describe the person-centered planning process in your state.

For adults, within seventy-two hours of admission to an adult mental health-funded service, an initial assessment that identifies and addresses the consumer's immediate health and safety needs is conducted for each consumer. The initial assessment informs the consumer's Individual Service Plan (ISP) and views the relationship with the consumer and family members as a partnership that supports the consumer's hopes, dreams and goals. At a minimum, the ISP is reviewed by the case manager on a quarterly basis to determine if the goals and objectives meet the needs of the consumer based on the most recent clinical review of the service documentation and assessment of functioning. Based on the frequency of service provision, an ISP review is expected to be done when progress is determined, new opportunities for improvement emerge, and growth is seen building upon existing strengths.

Discharge planning starts on the initial day of the ISP. The discharge plan of the ISP incorporates a plan that describes transition from current services to other appropriate less intensive services and summarized and estimated timetable to achieve the goals and objectives in the service plan. Further, ongoing consultation with the consumer and person-centered planning team is assessed to assure that the consumer's changing strengths, preferences, functional levels, social and cognitive capabilities is addressed at the time of discharge.

For youth, the Mental Health Treatment Plan (MHTP) is individualized for each youth and is developed through a collaborative process driven by the family/guardian and youth that includes the contractor, family and Care Coordinator. The MHTP goals identify realistic, measureable outcomes that are directly related to the youth's ability to move into a more normalized, less restrictive setting. The MHTP identifies evidence-based treatment interventions that are the most promising options for meeting that youth's individualized goals and objectives. Progress on the plans are tracked continuously and treatment is revised as necessary with youth, family/guardian and Family Guidance Center collaboration. The treatment planning process begins with the pre-admission welcome meeting and culminates in a document that includes expected intensity of treatment and treatment timelines, crisis and discharge plans. Initial plans should be submitted within seven (7) calendar days of intake or prior to admission.

For youth, discharge planning begins at the time of the pre-admission meeting to ensure that any potential obstacles to discharge are recognized and addressed before the anticipated discharge date. Contractors, care coordinator, youth, family/guardian and other involved parties work together in this process. The discharge component of the MHTP spells out specific, realistic, measureable discharge criteria that are consistent with the youth's original behaviors/symptoms that resulted in the admission, describe a projected timeline for meeting them, and identify any aftercare resources needed. As treatment progresses, all parties are expected to regularly review discharge plans, discharge dates, step-down components, new admission dates and other factors to avoid unnecessary delays.

Does the state have any activities related to this section that you would like to highlight?

None at this time.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? j n Yes j n No
2. Are there any concretely planned initiatives in our state specific to self-direction? j n Yes j n No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

- a) How is this initiative financed?
- b) What are the eligibility criteria?
- c) How are budgets set, and what is the scope of the budget?
- d) What role, if any, do peers with lived experience of the mental health system play in the initiative?
- e) What, if any, research and evaluation activities are connected to the initiative?
- f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

The AMHD has a Representative Payee Program for consumers. Initially, the goal was for consumers to be able to plan, budget and implement their finances, but that didn't work. The plan is to increase the number of consumers who receive the Representative Payee Program.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Technical assistance is needed related to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that OHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☐ Yes ☒ No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ☐ Yes ☒ No

Does the state have any activities related to this section that you would like to highlight?

Not at this time.

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁵⁹ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

⁵⁹ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
Hawaii does not have any Federal or State recognized Tribes.
2. What specific concerns were raised during the consultation session(s) noted above?
N/A
Does the state have any activities related to this section that you would like to highlight?
N/A
Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Adult Mental Health Division (AMHD) state-operated Community Mental Health Centers (CMHC) are Branches of the AMHD/State of Hawaii Department of Health, Behavioral Health Administration. The state-operated CMHC system provides mental health treatment and case management services for adults, eighteen (18) years or older who have a serious mental illness (SMI) diagnosis and meet AMHD eligibility criteria. Many adults with SMI also have a co-occurring alcohol or substance use diagnosis. This co-morbidity complicates the care and treatment of their mental illness; therefore, the CMHC system has implemented an Integrated Dual Diagnosis (IDDT) treatment approach and maintains a close working relationship with chemical addiction service providers in the community.

Outpatient Treatment services are guided by a Recovery Team consisting of the consumer, the prescribing provider (MD/APRN-Rx who serves as the Recovery team lead), the assigned case manager (the single point of accountability for coordinating the services received by the consumer), nursing, MI/SA and/or a Forensic Coordinator for dual diagnosis or legally encumbered consumers and a Clubhouse staff member when Clubhouse membership exists. Additionally, when consent is given and, as appropriate, family members and other ancillary community providers are encouraged to participate in Recovery planning.

An Initial Plan of Treatment is written by the admitting prescribing provider on admission and a Master Recovery (Treatment) Plan is completed within thirty (30) days. The Master Recovery (Treatment) Planning process includes the consumer and Recovery Team members who utilize assessment information and the resultant Interpretive Summary to develop the Master Recovery Plan. Consumer input during the assessment process, indicating their expectations and preferences, and their indication of agreement with the plan of care is shown by acknowledgement of acceptance and/or the signing of the Recovery Plan. The Recovery Plan is updated every six (6) months and/or when a significant change in clinical status or life circumstances occurs. Outpatient Treatment services are primarily provided within a Community Mental Health Center or at a satellite clinic site. The AMHD system has four (4) CMHC sites and seven (7) satellite sites on six (6) of the Hawaiian Islands. Additionally, treatment services are provided at other sites on an "as needed" basis. The geographically dispersed mental health treatment service sites across the state facilitate accessibility to AMHD eligible consumers receiving state-operated CMHC services.

Outpatient Treatment Services include:

- Eligibility Determination screening (information, referral, and linkage services for those found ineligible)
- Crisis services
- Psychiatric evaluation
- Medication assessment and management
- Case Management Assessment
- Nursing health screening, and medication administration, monitoring
- Other assessments as appropriate (Substance Abuse, Forensic Risk, Trauma)
- Recovery (treatment) Planning meetings
- Individual/Family/Group Psychotherapy
- Wellness education and psycho-education support groups
- Certified Peer Specialist support and mentoring
- Referral for psych-social, skill building and transitional employment services
- Ongoing communication/collaboration between the CMHC and other providers: e.g. courts and corrections, the judiciary, hospitals, specialized treatment providers, housing, SSI, and third party payors.
- Referral for transfer, discharge and follow-up.

Further, the CMHCs have incorporated the International Clubhouse model into provision of rehabilitation services. A primary focus of rehabilitation services is to maintain clinical stability, support community integration and tenure and improve the quality

of life for adults with severe mental illness to live in the community. Members who chose to be supported in their recovery through psychosocial rehabilitation and vocational training within the CMHC Clubhouse Programs (CMHC Rehabilitation Service Sections) are referred for membership while in the community at any level of care in the AMHD system. Additional enrichment of the Recovery model is achieved through the support of Hawaii Certified Peer Specialists (HCPS) who embody recovery principles sharing their life experiences through role modeling, mentoring, relationship and community re-integration skill building with members.

CHILDREN'S MENTAL HEALTH SERVICES

In Hawaii, it is always a goal and value to place children and youth in the least restrictive environment. Thus, the Child and Adolescent Mental Health Division (CAMHD) has a wide array of outpatient services.

Outpatient Treatment Services for Youth include:

- Ancillary Services
- Respite Supports
- Psychosexual Assessment
- Mental health Evaluation
- Psychological Testing
- Summary Annual Evaluation
- Psychiatric Evaluation
- Medication management
- Individual Therapy
- Group Therapy
- Family Therapy
- Functional Family Therapy
- MultiSystemic Therapy
- Intensive In-Home Therapy
- Intensive In-Home Paraprofessional Support
- Intensive Independent Living Skills
- Independent Living Skills Paraprofessional Support

Many youth receiving services from CAMHD have mental health disorders that co-occur with substance abuse, intellectual or developmental disabilities, or medical impairments. The presence of co-occurring disorders is assessed with all youth at the point of initial evaluation, as well as routinely during the course of on-going treatment. CAMHD requires all its providers to provide integrated treatment for co-occurring substance abuse disorders and mental health treatment with appropriate accommodations for youth with medical impairments. Youth with a primary diagnosis of substance abuse can access services from our sister agency, the Alcohol and Drug Abuse Division (ADAD). When necessary, ADAD has some bed capacity available for residential treatment.

In Hawaii, youth are not committed to the state mental health hospital.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

- | | |
|---|--|
| a) Physical Health | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) Mental Health | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Rehabilitation services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d) Employment services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e) Housing services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f) Educational Services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g) Substance misuse prevention and SUD treatment services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h) Medical and dental services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i) Support services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k) Services for persons with co-occurring M/SUDs | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please describe as needed (for example, best practices, service needs, concerns, etc)

3. Describe your state's case management services

ADULT SERVICES

The state operated Community Mental Health Centers (CMHCs) for adults is mandated to provide case management services. Case management services provide individualized, goal focused, recovery based outpatient clinical services which include care coordination activities that enable consumer to lead meaningful lives in the community. In the CMHCs, the case manager is the single point of accountability for facilitating and coordinating case management services, which enables the consumers to maintain their independence within the community.

The goal of case management services is to provide goal-oriented and individualized supports, which focuses on improved self-sufficiency for consumers served through assessment, planning, linkages, advocacy, coordination and monitoring activities. To achieve this, case management services are:

- Consumer-centered, i.e., services are based on, and responsive to the needs of consumers rather than the needs of the system or the needs of providers.
- Incorporated into consumers' self-help approaches and are provided in a manner that allows the consumers to retain the greatest possible control over their own lives. As much as possible, consumers are to set their own goals and decide what services they will receive.
- Culturally and linguistically sensitive. For example, services are available and accessible to all eligible individuals regardless of race, age, gender, religion, sexual orientation and language.
- Built upon the assets and strengths of the consumers in order to help them maintain a sense of identity, dignity and self-esteem.
- The consumers' Recovery Plan include, but not limited to, goals in the consumer's own voice that are reflective of their needs, strengths, and short and long-term objectives.
- Normalized and incorporate natural supports, where services are offered in the least restrictive, most natural setting possible. Consumers are encouraged to use the natural supports in the community and should be integrated into the normal living, working, learning and leisure time activities of the community.
- Adapted to meet the needs of the subgroups of severely mentally ill individuals, such as, the elderly; young adults and youth in transition to adulthood; individuals with mental illness and substance use problems, medical co-morbidities, and/or individuals with mental illness who are homeless.
- Accountable to the users of the services and monitored by the State to assure quality of care and continued relevance to consumer needs. Consumers and their supports where applicable, are involved in the planning and implementation of services.
- Coordinated through mandates or written agreements that requires ongoing communication, collaboration, and linkages between multiple agencies, when needed, to ensure continuity of care.

CHILDREN'S SERVICES

The state operated Family Guidance Center system for children with serious emotional disturbance (SED) includes intensive case management services. Case management services are provided in an individualized, strengths-based, youth-guided and family/guardian-centered manner. Every youth registered in the children's mental health system has an assigned care coordinator who will ensure timely, appropriate and coordinated service delivery.

Key functions of the Care Coordinators are to:

- A. Develop collaborative working relationships with other child serving agencies;
- B. Monitor all services; and
- C. Participate, with the family, in the development of the Mental Health Treatment Plan (MHTP) and quarterly MHTP reviews.

The Mental Health Care Coordinator (MHCC) is the case manager who is responsible for engaging the youth and family and assisting parents with coordinating the youth's education, health care and mental health services. Parent Partners are also available to provide peer support to parents in this regard. MHCCs are responsible for referring the youth for appropriate state mental health services, maintaining contact with the youth/family, ensuring the timely and efficient delivery of quality services, and continuous monitoring of the effectiveness of interventions to assure that youth receive medically necessary care.

The youth's MHCC is responsible for convening an initial Coordinated Service Plan (CSP) meeting within thirty (30) days of eligibility determination or immediately if the youth has immediate needs and assuring service delivery within thirty (30) days of identification for routine services. The MHCC coordinates regular home visits, school visits, and community contacts as indicated in the CSP. When appropriate, responsibilities also include coordination of care with Family Court, and Department of Human Services and other state and community agencies. The MHCC is responsible for facilitating the integration, coordination, and monitoring of behavioral health services across programs and domains and for communicating important clinical developments to the Branch Utilization Review Team.

The MHCC is responsible for ensuring that needed services, interventions and strategies are identified and delivered in a coordinated manner and in partnership with families. This includes the following activities:

- Ensuring that a sound clinical assessment is conducted that identifies the strengths and needs of the youth and family;
- Convening team meetings to conduct strength-based planning via the Coordinated Service Plan process;
- Responsible for the written Coordinated Service Plan as discussed and for obtaining the signatures of all participants attesting agreement.
- Implementation of the Coordinated Service Plan which includes linkages to other services or programs, referrals to natural community supports, advocacy and coordination with outside agencies and individuals;
- Performing ongoing monitoring and evaluation of the effectiveness of the Coordinated Service Plan and services;

- Through team participation, revising/adapting the plan as needs change;
- Ensuring that the Child and Adolescent Service System Program (CASSP) Principles always guide planning for all services; and
- Upon first contact, and in addition to the prescribed intake procedure, provide the client/parent/legal guardian with a copy of the CAMHD flyer entitled "Notice of Privacy Practice" and the CAMHD client/family rights handbook entitled "Consumer Handbook." Provide explanation, ensure that the family understands these rights, and obtain parental signature that attests to same.

4. Describe activities intended to reduce hospitalizations and hospital stays.

ADULT SERVICES

Adding to the complexity of case management services is the CMHCs focus on a sub-population of individuals who are forensically encumbered. Due to behaviors resulting from their mental illness individuals frequently become involved with the criminal justice system resulting in court ordered inpatient treatment and subsequent referral into CMHC case management services. The CMHCs closely interfaces with the AMHD state-operated inpatient facility, Hawaii State Hospital, and AMHD contracted providers, and receives mental health treatment and case management referrals for consumers with forensic encumbrances from these hospitals.

The consumer with forensic encumbrances, receives forensic focused evaluation, case management, group therapy and monitoring services. Therefore, the CMHC Forensic Service Sections offer unique supports for consumers through the provision of structure and interventions to prevent re-arrest and/or to facilitate diversion from involvement with the criminal justice system. Two such supports interfacing with case management include Fitness Restoration and Conditional Release programming. The statewide network of CMHC Forensic Coordinators consult with case management teams and also monitor and report to the court regarding the status of consumers who are court ordered to receive outpatient treatment and case management services within the AMHD system of care.

The state-operated CMHCs also provides Jail Diversion program interventions to divert consumers with a SMI diagnosis and misdemeanor and non-violent charges from incarceration and/or inpatient hospitalization. Consumers meeting Jail Diversion criteria are referred for approval by the court for community placement, treatment and case management services. Because of this involvement with the courts, a close working relationship exists between the CMHC case managers, Forensic Coordinators, Court Evaluation Branch and the State of Hawaii Judiciary.

A primary focus of community based case management is to maintain clinical stability for adults with severe mental illness, and consumers who chose to be supported in their recovery through psychosocial rehabilitation and vocational training within the CMHC Clubhouse Programs (CMHC Rehabilitation Service Sections). Further enrichment of the Recovery model is achieved through the employment of Hawaii Certified Peer Specialists (HCPS) who share their life experiences through role modeling, mentoring, relationship and community re-integration skill building with these consumers.

The AMHD funds and provides staffing for a statewide Crisis Line of Hawaii. The services are intended to keep an individual out of the hospital by referring them to the most appropriate resources and services in the community, which include assessment, diagnosis, crisis counseling, treatment and/or referral during crisis interventions and admission screening to ensure rapid referral and linkage to appropriate interventions. It is the policy of the AMHD that all persons statewide may contact the Crisis Line of Hawaii 24-hours a day, seven days a week, to request crisis services due to an urgent or emergent situation. A trained telephone staff member will screen every request for crisis services and all urgent and emergency inquiries will receive an immediate response. The AMHD also contracts with private organizations in the community to provide an array of crisis intervention services including: Crisis Mobile Outreach, Crisis Support Management, Licensed Crisis Residential Services, and a Crisis Management Fund. The services within the crisis services program are listed below:

Crisis Line of Hawaii: This is a 24-7 Crisis and Suicide Hotline with membership in the National Suicide Prevention Lifeline (SAMHSA). The Crisis Line staff provides supportive listening and crisis counseling, dispatch and authorization of 24-hour crisis services, and serves as the after-hours link for oral Ex-Parte orders.

Crisis Mobile Outreach (CMO): CMO provides assessment and intervention services for adults in an active state of crisis. This service is available twenty-four (24) hours a day, seven (7) days a week and can occur in a variety of settings including the consumer's home, local emergency department, etc. This service provides an opportunity for immediate crisis intervention and de-escalation, which includes a thorough assessment of risk, mental status and medical stability, and exploration of service options in the community.

Crisis Support Management (CSM): CSM provides time-limited support and intervention services to individuals who are in crisis and not linked with services or who do not have a Division-assigned case manager. Services assist the individual in returning to a pre-crisis state and gaining access to necessary services.

Licensed Crisis Residential Services (LCRS): The LCRS offers short-term, acute interventions to individuals experiencing or recovering from a psychiatric or behavioral health crisis. This is a structured residential alternative or diversion from psychiatric inpatient hospitalization. LCRS services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. This program provides services which address the psychiatric, psychological,

and behavioral health needs of the individual.

Crisis Management Fund: This fund is used to provide short-term supplies of psychiatric medications, or crisis shelter when the LCRS is full or not appropriate for the case.

CHILDREN'S SERVICES:

CAMHD and its contractors have procedures to ensure the safety and well-being of youth at all times. These procedures are designed to manage, control or alter potentially harmful conditions, situations, or operations including those leading to abuse, neglect and sexual exploitation, or induced by the youth's high risk behaviors to prevent or reduce the probability of physical or psychological injuries to youth.

The Child and Adolescent Mental Health Division (CAMHD) makes every effort to place children in the least restrictive environment and limits lengths of stays to time frames that have been shown to maximize youth outcomes. CAMHD has analyzed its own local data to determine the appropriate and effective length of stay guidelines for each service in its array. By using local aggregate outcome data, CAMHD was able to determine the most appropriate time frame for each level of care, and incorporated them into the service reauthorization standards. The Child and Adolescent Functional Assessment Scale (CAFAS) and Monthly Treatment and Progress Summary (MTPS) data to analyzed to determine the time frame in which the majority of youth showed maximum improvement. This time frame serves as the threshold for which a second level of review is needed in order to continue the service, since only a minority of youth showed continued improvement beyond this point in time. The thresholds are used to guide treatment time frames. Treatment beyond any given threshold must have a Utilization Review Team review to ensure the youth will continue to benefit from further treatment. CAMHD Care Coordinators and contractors together plan the transition to the greater or lesser level of support and services.

NOT FINAL

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	12.56%	n/a
2.Children with SED	5-9%	n/a

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Please see the Attachment Section for Criterion 2.

NOT FINAL

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

- | | | |
|----|--|--|
| a) | Social Services | <input type="radio"/> Yes <input type="radio"/> No |
| b) | Educational services, including services provided under IDE | <input type="radio"/> Yes <input type="radio"/> No |
| c) | Juvenile justice services | <input type="radio"/> Yes <input type="radio"/> No |
| d) | Substance misuse preventiion and SUD treatment services | <input type="radio"/> Yes <input type="radio"/> No |
| e) | Health and mental health services | <input type="radio"/> Yes <input type="radio"/> No |
| f) | Establishes defined geographic area for the provision of services of such system | <input type="radio"/> Yes <input type="radio"/> No |

NOT FINAL

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

Services in Rural Areas

The Hawaii State Office of Primary Care and Rural Health coordinates federal, state, and local efforts aimed at improving the health of Hawaii's rural and medically underserved populations. The office works with rural health partners to collaborate on recruitment and retention of health professionals for rural populations. Initiatives that are currently being addressed is to promote health networks, provide grassroots input into statewide health planning, and to promote development of new services for rural areas.

The AMHD's definition of rural populations includes: Hawaii (Big Island), Kauai and Maui Counties. Services are provided in rural areas through contracted purchase of service providers, the Community Mental Health Centers (CMHC), satellite clinics and purchase of service providers. These counties consistently experience shortages of dentists, psychiatrists, psychologists, and social workers. Due to shortage of both primary care physicians and psychiatrists to serve remote, medically underserved areas, a collaboration team process has been developed with the Federally Qualified Health Centers to allow individuals to get their medical issues taken care of, and at the same time get their mental health illnesses addressed.

To help with the shortage of health professionals in the areas of mental and behavioral health, Hawaii has turned to Telehealth services to overcome the shortage. The Department of Health is now providing psychological services remotely via telephone, email, or videoconferencing. Based on a study by Gilman and Stensland, 62 percent of telehealth visits by Medicare beneficiaries in 2009 were for mental health services. Email usage tripled during 2008 to 2013, and videoconferencing usage increased from 2 percent to 10 percent. Clinicians have found that using Telehealth shows that consumers have benefited from improved care delivery, high levels of patient acceptance, expanded staff capacity, and cost savings.

Homelessness

Hawaii's number of homeless individuals has increased to its highest level in five years, which has resulted in an increase of unsheltered homeless individuals who now outnumber the sheltered. In the 2016 Point-In-Time (PIT) homeless study, conducted on January 24, 2016, revealed the total number of homeless individuals statewide was 7,921 individuals. This is a 4 percent overall increase from 7,620 individuals in 2015. The statewide increase was led by double digit overall increases on Kauai (30%) and Hawaii (12%). Both Oahu and Maui registered small, nearly one percent increases. The 2016 PIT increase was fueled by a 12 percent increase in unsheltered homelessness to 4,308 persons compared to 3,843 in 2015. Unsheltered homelessness rose on all four counties led by Kauai (40%), Oahu (12%), Hawaii (10%) and Maui (5%). The percent of homeless persons found to be unsheltered also continued its pattern of growth, with 54 percent of the statewide total unsheltered and 46 percent sheltered; continuing the four-year trend of a large percentage of unsheltered persons among those counted.

Homeless individuals with SMI are one of the most vulnerable populations in our society. In and out of jails, prisons, hospitals, and emergency rooms, this homeless subgroup is often at risk for suicide, homicide, and abuse. This population often utilizes the emergency room for mental health issues that could be treated through regular, preventive mental health care. Medical problems, developmental disability, and substance abuse which are often present, exacerbate schizophrenia and bipolar illnesses. The needs of this population include immediate access to housing options of choice, with provision of integrated services. This year, the PIT found that there were 631 adults with SMI, who were unsheltered, and 371 adults with SMI, who were sheltered for a total of 1,002.

AMHD will continue to work with the Project for Assistance in Transition from Homelessness (PATH) providers to link homeless individuals to case management services so that the realization of recovery will reduce the barrier of discrimination and stigma of mental illness. The AMHD's mainstream programs have also helped to address eligibility for chronically homeless individuals into AMHD services by using a "Presumptive Eligibility" approach. AMHD's array of services support the best practice, "Housing First" model, and provides services including, but not limited to, dedicated "homeless preference" housing, representative payee services, homeless outreach and crisis services. AMHD's Community Based Case Management services are provided by teams that service individuals who are homeless. The members on these teams are familiar with the dynamics of homelessness. As a result of the economic downturn that has plagued several states; the AMHD has changed its eligibility criteria so that more individuals with serious mental illness experiencing homelessness can access services. The AMHD is dependent on PATH providers to be advocates of change and to be link agents to engage with individuals with serious mental illness experiencing homelessness.

The children's division will use block grant funding to provide targeted services to a rural, homeless population on the Waianae Coast on the island of Oahu. The Waianae Coast is a rural community of predominantly Native Hawaiians. A trauma-trained Social Worker provides individual, group and family therapy to the homeless children and their families. Eligible children have symptoms of mental illness that meet diagnostic criteria and affect their functioning in school and community. Typically, the children exhibit problems in emotion and behavior, and those issues are often related to attachment disorders, trauma and maternal depression.

Parents and teachers report difficulties in dealing with these challenging behaviors. Over the past year, 25 individuals were provided mental health crisis management services, 156 children were provided group counseling, 175 Native Hawaiian families were provided case management services, and over 300 children were linked to health and mental health services, educational services, medical care, nutrition programs, and housing services.

Older Population

Hawaii's population, like other cities across the United States is aging. The nation's population has a distinctly older age profile than it did 16 years ago. The U.S. Census Bureau estimates that about 27 percent of Hawaii's population will be over age 60 by the year 2030, an increase of 33 percent. The median age of Hawaii residents increased from 36.2 to 38.0 percentage over the last decade, which is higher than the national average of 37.9 percent as of July 1, 2016. Despite this increase, older adults represented 10 percent of those who received AMHD services.

According to the Uniform Reporting System for 2016, over 6 percent of individuals served by the Hawaii mental health system were age 65 or older (6.9 percent were age 65 to 74 and 1.6 percent were age 75 or older. Research also shows a strong relationship between substance use and mental health disorders. The results show that 30-80 percent of individuals with substance use, who were admitted to substance use treatment, also had a mental health diagnosis.

Older adults receiving outreach services have shown increased likelihood of receiving case management services, decreased mental health symptoms and decreased incidence and length of psychiatric hospitalization. Hawaii has found that community-based, multidisciplinary mental health treatment teams are effective with older adults. As a result, no one service system is equipped to meet the multiple and complex needs of the older population with SMI. Effective services require a coordination and collaboration among state providers and purchase of services providers in providing mental health, health care, substance use, and social services treatment, in working with this population.

NOT FINAL

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

Please see the Attachment Section for Criterion 5.

NOT FINAL

Footnotes:

NOT FINAL

Criterion 2: Mental Health Data System Epidemiology

Estimate of the Incidence and Prevalence in the State of Serious Mental Illness among Adults

Criterion 2 of the MHBG application is directed to discussion of the estimated prevalence of serious mental illness in Hawaii and the quantitative targets to be achieved in the system care in Criterion 1. This is covered in the National Outcome Measure No. 1: Adults Receiving AMHD Services (Treated Prevalence). This discussion also includes statewide and county specific information.

SAMHSA's recommended estimated prevalence rate of serious mental illness (SMI) is 5.4 percent of the adult population nationally (June 24, 1999 Federal Register, Vol 64 No. 121 pages 33890-33897). Application of 5.4 prevalence percentage of Hawaii's SMI adult population is shown in Table 1.

Table 1
Estimate of Statewide Prevalence for Adults with SMI
FY 2016

County	Adult Population ¹	Estimated Adult SMI Prevalence (5.4%)	Number Served FY 2016 ²	Percent SMI Prevalence Served
Statewide Total	1,127,564	60,888	7,647	12.56

Application of the 5.4 percent prevalence rate to the SMI population by County, utilizing the latest available population figures by County and Age (2015) is shown in Table 2. According to the U.S. Census Bureau, the estimated 2015 state population has increased slightly, but the distribution of residents has remained the same from the 2010 Census. Oahu continues to be the home of nearly three-fourths (70%) of the state's population (789,785 residents), while 13.6 percent live on the Hawaii (Big Island) (153,499 residents), 11.4 percent on Maui (128,027 residents), and 5.0 percent or 56,253 residents reside on Kauai County. The prevalence rate shows that Kauai had the highest percent of consumers served at 23.10 percent, then Hawaii County (18.80%), Maui County (15.48%), with Oahu having the lowest percent of consumers served (10.12%).

The AMHD system of care is only one part of the treatment system for adults with SMI. Significant numbers of persons are also served through the private sector, Hawaii's Pre-paid Health Insurance Act, and government insurance programs including Medicaid, Medicare, and MED-QUEST. The preponderance of residency on Oahu necessitates a larger proportion of services to be delivered within the City and County of Honolulu, which must be balanced against provision of a comprehensive integrated system of care in all counties.

¹ State of Hawaii Data Book, Department of Business, Economic Development, and Tourism. Table 1.34 – Resident Population by Age, by County: 2015.
<http://www.hawaii.gov/dbedt/info/economic/databook/db2015/section01.xls>

² Statewide total is unduplicated; County data is unduplicated, but is not additive to state total since some consumers move to a different county periodically.

Treated Prevalence

The number of persons who received AMHD services in FY 2016 is reported in Table 3 by County and Race/Ethnicity. The two largest populations served in the State by race/ethnicity are Whites (23.9%), and Asians (17.7%). Asians are more often served on Oahu (23.0%) and Kauai (17.1%) than on Maui (10.7%) and Hawaii (8.1%). Whites are more often served on the neighbor islands (Hawaii (32.3%); Kauai (28.9%), and on Maui (27.2%) than on Oahu (19.1%), which may reflect in-migration of this group during recent population increases to rural areas. The percent of Native Hawaiians and Other Pacific Islanders served is fairly commensurate on all the islands, although Oahu serves a percent (11.7%) above the state average (10.2%). For approximately one third (33%) of those served, information regarding race/ethnicity was not available.

Table 2
Estimated Adult SMI Prevalence by County, FY 2015, and Number Served FY 2016

County	Adult Population 2015		Estimated Adults SMI Statewide Prevalence (5.4%)	Number SMI Served FY 2016	Percent SMI Served (5.4%) Prevalence of Each County
	Number	Percent			
Oahu	789,785	70.0	42,648	4,317	10.12
Hawaii	153,499	13.6	8,289	1,558	18.80
Maui	128,027	11.4	6,913	1,070	15.48
Kauai	56,253	5.0	3,038	702	23.10
Statewide Total	1,127,564	100.0	60,888	7,647	12.56

Table 3
Adults Served by County/State and Race/Ethnicity: FY 2016 Uniform Table 2A

Race/Ethnicity	State		Oahu		Hawaii		Maui		Kauai	
	#	%	#	%	#	%	#	%	#	%
American Indian / Native Alaskan	38	0.5%	14	0.3%	9	0.6%	7	0.7%	8	1.1%
Asian	1,353	17.7%	993	23.0%	125	8.0%	115	10.7%	120	17.1%
Black / African American	135	1.8%	105	2.4%	17	1.1%	8	0.7%	5	0.7%
Native Hawaiian / Other Pacific Islander	779	10.2%	505	11.7%	142	9.1%	93	8.7%	39	5.6%

Race/Ethnicity	State		Oahu		Hawaii		Maui		Kauai	
	#	%	#	%	#	%	#	%	#	%
White	1,824	23.9%	826	19.1%	504	32.3%	291	27.2%	203	28.9%
More than One Race	1,027	13.4%	580	13.4%	248	15.9%	109	10.2%	90	12.8%
Race Not Available	2,491	32.6%	1,294	30.0%	513	32.9%	447	41.8%	237	33.8%
Total	7,647	100.0%	4,317	100.0%	1,558	100.0%	1,070	100.0%	702	100.0%

Prevalence Estimate for Youth

Research has shown prevalence rates of youth with Serious Emotional Disturbances (SED) to range anywhere from 5% to 20%. According to the President's New Freedom Commission's report, *Achieving the Promise: Transforming Mental Health Care in America*, about 5% to 9% of children ages 9-17 have a serious emotional disturbance³. Using the 2010 census, the prevalence of SED by county for individuals aged 10-19 is shown in the table below, and is expected to be 8,375 – 15,077 statewide.

Table 4
Estimated Range of Numbers of SED Youth aged 10-19 years by County, based on 2010 Census

County	Total Youth	Lower SED Number (5%)	Upper SED Number (9%)
Hawaii	23,610	1,180	2,125
Honolulu	116,491	5,824	10,484
Kauai	8,201	410	738
Maui	19,231	961	1,730
STATE	167,533	8,375	15,077

For planning purposes, CAMHD's Program Improvement and Communications Office (PICO) evaluates CAMHD's population, services and outcomes. The evaluations focus on trends over time and whether the Division is making progress in improving key performance measures. CAMHD also partners with the University of Hawaii on multiple Health Information Technology and clinical improvements. In the past, the partnership has worked on translating systems data into actionable information and identifying

³ Friedman, R. M., Katz-Levey, J. W., Manderschied, R. W., & Sondheimer, D. L. (1996b). Prevalence of serious emotional disturbance in children and adolescents, cited in R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental Health, United States, 1996* (pp. 71–88). Rockville, MD: Center for Mental Health Services.

predictors of client success or identifying early risk profiles for the purposes of improving clinical outcomes.

Hawaii is a place of multiple ethnicities and cultures. Because of this diversity, CAMHD pays special attention to these factors. The 2015 U.S. Census estimates shows that 83 percent of Hawaii's youth between 0 to 17 years of age belong to a racial or ethnic minority group including Asian American, Native Hawaiian/other Pacific Islander, African American, Hispanic/Latino(a), and American Indian/Alaskan Native. Many of these groups also have higher rates of poverty in the state, and research shows a strong relationship between poverty and poor mental health (Lund et al., 2010). In fact, previous studies have found that Asian American and Native Hawaiian youths display more symptoms of anxiety and depression than White children (Andrade et al., 2006; Austin & Chorpita, 2004; Okamura et al., 2016).

According to the Healthcare Association of Hawaii Needs Assessment Report (HAHNAR), access to both mental health services and children's health services are an area of racial disparity for several racial and ethnic minority groups in Hawaii. The HAHNAR notes the need to provide opportunities for early intervention of mental health issues.

Table 5
Youth Served by Race

FY2016 Race (Unduplicated)	N	% of Available
American Indian or Alaska Native	5	0.3%
Asian	143	8.5%
Black or African-American	14	0.8%
Native Hawaiian or Other Pacific Islander	189	11.3%
White	217	13.0%
Other Race	21	1.3%
MultiRacial	1084	64.8%
Not Available	823	33.0%

In 2016, CAMHD saw 2,496 registered youth and for those with race information, 87 percent identified either as belonging to a racial/ethnic minority group or as being multiracial.

Criterion 5: Management Systems

Financial Resources, Staffing, and Training for Mental Health Service Providers Necessary for the Plan

In FY 2016, the total AMHD State and Federal expenditures for community-based, hospital-based and administration services were \$129,526,375. The AMHD State expenditures for administration, community-based services were \$122,150,105 in General Funds and \$5,799,085 in Special Funds. The 2016 AMHD amount of Federal Funds expended is 1,391,916 for purchase of service providers and community support, and \$185,269 in administrative costs for a total of \$1,577,185.

Table 1
FY 2016 AMHD Expenditures

	TOTAL	GENERAL FUNDS	SPECIAL FUNDS	FEDERAL FUNDS
Central/Leeward Oahu TSS	548,645	547,126	1,519	0
East Honolulu TSS	1,256,849	1,226,217	30,632	0
West Honolulu TSS	2,641,433	2,641,368	65	0
Windward TSS	2,026,850	2,026,765	85	0
Hawaii County CMHC Branch	4,563,300	4,466,052	97,248	0
Kauai CMHC Branch	1,832,520	1,832,435	85	0
Maui CMHC Branch	1,754,225	1,364,970	389,255	0
Subtotal - CMHC	14,623,822	14,104,933	518,889	0
POS & Other Community Services	41,202,869	34,530,757	5,280,196	1,391,916
Subtotal – Community Support	55,826,691	48,635,690	5,799,085	1,391,916
Court Evaluation Branch	833,582	833,582	0	0
Subtotal Community Services	56,660,273	49,469,272	5,799,085	1,391,916
Hawaii State Hospital	67,287,549	67,287,549	0	0
Subtotal – Direct Services	123,947,822	116,756,821	5,799,085	1,391,916
Administration	5,578,553	5,393,284	0	185,269
TOTAL	129,526,375	122,150,105	5,799,085	1,577,185

In FY 2017, the total AMHD State and Federal expenditures for community-based, hospital-based, and administration services were \$140,600,697. The AMHD State expenditures for administration, community-based and hospital-based services were \$135,481,125 in General Funds, and \$3,938,361 in Special Funds for a total of \$139,419,486. The 2017 AMHD amount of Federal Funds is \$1,074,021 in Community Services and \$107,190 in Administration for a total of \$1,181,211. Both Tables 1 & 2 will be

used to calculate the Maintenance of Effort along with expenditures from the Child and Adolescent Mental Health Division.

Table 2
FY 2017 AMHD Expenditures

	TOTAL	GENERAL FUNDS	SPECIAL FUNDS	FEDERAL FUNDS
Central/Leeward Oahu TSS	3,293,344	3,216,142	77,202	0
East Honolulu TSS	1,369,749	1,337,128	32,621	0
West Honolulu TSS	2,477,867	2,477,867	0	0
Windward TSS	2,177,638	2,177,638	0	0
Hawaii County CMHC Branch	4,269,182	4,212,372	56,810	0
Kauai CMHC Branch	1,940,523	1,940,523	0	0
Maui CMHC Branch	1,815,007	1,708,980	106,027	0
Subtotal - CMHC	17,343,310	17,070,650	272,660	0
POS & Other Community Services	35,890,793	31,151,071	3,665,701	1,074,021
Subtotal – Community Support	53,234,103	48,221,721	3,938,361	1,074,021
Court Evaluation Branch	1,137,632	1,137,632	0	0
Subtotal Community Services	54,371,735	49,359,353	3,938,361	1,074,021
Hawaii State Hospital	80,438,406	80,438,406	0	0
Subtotal – Direct Services	134,810,141	129,797,759	3,938,361	1,074,021
Administration	5,790,556	5,683,366	0	107,190
TOTAL	140,600,697	135,481,125	3,938,361	1,181,211

Staffing

The AMHD, as of June 2017, employs a total of 902 staff, although 1,101 has been allocated. This includes 600 staff at the Hawaii State Hospital, 216 staff at the Community Mental Health Centers (CMHCs), 10 staff at the Court Evaluation Branch, and 76 staff in Administration. Despite Hawaii having one of the lowest unemployment rate (2.7% as of June 2017) compared to 4.4 percent in the nation and workforce shortages, the AMHD management and clinical positions have remained relatively stable. Case management and forensic staff are largely in place in the CMHCs. Nursing and psychiatric shortages continue especially in the rural areas. Staff case management qualifications have been amended to widen the base for potential hires for contracted providers. AMHD will continue central recruitment for major shortage areas for physicians.

Planned Training for FY 2018:

- System-wide Training for all Clinical Staff regarding Billing Codes and corresponding documentation;
- The Annual Hawaii Peer Specialist Certification process for the 40-hour training, written test and oral interview;
- Basic Staff Competencies for Community Based Case Management;
- Provide Core Mental Health Services for Adults and Older Adults with Serious Mental Illness;
- Non-Violent Crisis Intervention;
- Business Compliance Training;
- Cultural Competency Training;
- Contracts & Procurement Training;
- Orientation for New Providers of New Services;
- Promote and Support ASIST (Applied Suicide Intervention Skills Training)
- Health Insurance Portability & Accountability Act Privacy Training; and
- Health Insurance Portability & Accountability Act Security Awareness.

FY 2018-2019 AMHD Planned Expenditures

Activity	Description	Mental Health Block Grant
Other 24 Hour Care	Mental Health Kokua	\$100,000.00
Ambulatory/Community Non-24 Hour Care	Mental Health Emergency Worker, Crisis Supports, Honolulu Police Department Collaboration	\$608,000.00
Administration		\$58,379.00
TOTAL		\$766,379.00
Table 6b: Non-Direct Service Activities	State Council on Mental Health	\$30,000.00
	Information Systems	\$30,000.00
	Infrastructure Supports	\$20,000.00
	Partnerships Community Outreach, Needs Assessment	\$231,203.00
	Quality Assurance & Improvement	\$40,000.00
	Research & Evaluation	\$30,000.00
	Training & Education	\$20,000.00
		\$401,203.00
AMHD Allocation GRAND TOTAL		\$1,167,582.00

Child and Adolescent Mental Health Division Staffing and Resources

The Child and Adolescent Mental Health Division (CAMHD) is led by a CAMHD Administrator and consists of both line and staff offices. The staff offices are maintained at the state level with 82 positions. The line offices are organized into three (3) CAMHD branches consisting of an Oahu Services Branch, a Neighbor Island Services Branch and a Family Court Liaison Branch. The Oahu Branch and Neighbor Island Branch are further divided into seven (7) community-based Family Guidance Centers (FGCs). A network of approximately 16 contracted provider agencies located throughout the State provides an array of home and community-based and residential treatment services.

The CAMHD state office includes the Central Administrative Services Office, Clinical Services Office, Healthcare System Management Office and the Program Improvement and Communications Office.

The Central Administrative Services Office is responsible for budgeting, accounting, personnel resource management, and contracting. This section is also responsible for maximizing alternative funding sources, such as Title XIX, Title IV-E, and grants.

The Clinical Services Office has overall responsibility for providing clinical services, clinical leadership, oversight, technical assistance, and training to the CAMHD branches and contract providers to ensure evidence based practices are used and clinical services meet or exceed national standards; quality management responsibilities, such as monitoring the branches implementation of policies and procedures and assessing service capabilities; developing and evaluating the adequacy of and maintaining an array of behavioral health services with sufficient capacity and resources to provide clinically appropriate services to CAMHD consumers; assuring accountability for all professional services provided; and ensuring compliance to clinical standards for Medicaid behavioral health providers.

The Healthcare System Management Office is responsible for: providing understanding and knowledge of Medicaid and healthcare reform to the CAMHD staff; ensuring operations and business practices are developed, coordinated, structured, and maintained to comply with federal and state health records, billing and credentialing standards and requirements, to include maximizing on-going and alternative sources of funding to support an array of comprehensive mental health services to children, adolescents, and their families. This Office is also responsible for protecting system integrity, to include, reviewing and auditing coding practices and maximizing revenue generation; overseeing the CAMHD compliance with HIPAA federal and state requirements; developing and maintaining credentialing and privileging criteria for mental health professionals within CAMHD and external providers, to include ensuring system compliance with HIPAA and provider credentialing; and developing, implementing, maintaining, and monitoring the CAMHD quality assurance procedures. Under the Healthcare System Management Office, CAMHD's Management Information System (CAMHMIS) provides the organizational foundation for CAMHD's outcome tracking, utilization management, accountability systems, billing and general registration, as well as information technology initiatives, including the electronic health records system, and telehealth. The electronic health record is designed to support:

- Use of information to engage families in care;
- Improve quality, safety, and efficiency, leading to improved health outcomes;
- Support standardization of community-based operations,

- Increase revenue from Federal sources through increased accurate billing for existing services; and
- Support private insurance contracting for unique services.

The Program Improvement and Communication Office is responsible for: overseeing internal communications and communications that connect CAMHD to providers, the public, and government and private agency sectors; planning, developing, implementing, and reviewing written operational policies and procedures; developing, implementing, and maintaining a statewide reporting system; and conducting planning, grant writing, special studies, and research activities. The children's mental health planner is housed in this Office and provides the planning, program development, contract management and budgetary oversight of the SAMHSA children's mental health block grant; strategic planning, monitoring and reporting; and legislative policy analysis. The children's mental health planner recently completed the development policies and procedures around the management of the Block Grant. The policies and procedures specify how the grant may and may not be used, the process to manage the contractual and fiscal obligations, the calculation of the maintenance of effort and the children's set-aside.

Community-based Family Guidance Centers

The community-based Family Guidance Centers (FGCs) are responsible for providing high quality, culturally competent, evidence-based treatment services to eligible children and adolescents. The FGCs are strategically located in geographic areas that correspond with the Department of Education school districts. Three FGCs are located on Oahu, where close to 72% of the state's population reside. Also, there is one FGC each on the rural neighbor island counties--Kauai, Maui, and the Big Island, with partial coverage for the islands of Molokai and Lanai. Most of the FGCs also have satellite offices. The geographic placement of FGCs and their satellite offices help to address the needs of Hawai'i's ethnic and racial diversity, which differs by geographic location.

Each FGC is led by a Center Chief, and is staffed with a psychiatrist, one or more psychologists, a quality assurance specialist, a fiscal officer, and social workers and mental health care coordinators to provide intensive case management. Services provided by the centers include clinical team management, intensive case management, direct service provision, authorization for contracted services, and utilization and quality monitoring. The FGCs work in partnership with youth and their families to design and implement individualized service plans.

The Family Court Liaison Branch (FCLB) provides screening, assessment, evaluative, diagnostic, treatment, and consultative services to youth with mental health challenges in the state juvenile justice system. FCLB provides mental health treatment linkages between the Family Court, Hawai'i Youth Correctional Facility, and the State's Detention Home. The FCLB works in partnership with families and the court system to design and implement individualized service and treatment plans suitable to the specialized needs of children and youth involved with the Hawai'i juvenile justice system. FCLB differs from CAMHD's other branches because it does not have a geographical limitation, and provides direct services in collaboration with other state agencies and Family Court. FCLB staff spends considerable time and effort in conducting mental health assessments of youths at the direction of Family Court judges and in advocating for treatment of such youth in less restrictive settings, where appropriate.

Supervision

CAMHD is committed to quality service through regular, ongoing, strength-based, skill building supervision of all staff that provide direct services to youth. CAMHD and each Contractor shall have clear lines of accountability and a clearly described supervision structure for all employees and independent contractors.

Contractors must have policies and procedures and the mechanism to ensure supervision of all direct services and professionals by a Qualified Mental Health Professional (QMHP) and paraprofessional staff by a QMHP or a Mental Health Professional (MHP) who is supervised by a QMHP. The Contractor is responsible for maintaining and tracking supervision records.

All personnel (employees or subcontractors) must have an individualized supervision plan based on a needs assessment completed annually by their respective supervisor. Documentation of individual supervision session must include dates and duration, name and credentials of supervisor, goals and interventions, and summary of the sessions. Documentation must be included in the individual's supervision file and must include documentation of follow-up and consistency from previous supervision sessions.

Evaluation of Staff Performance

All CAMHD employees and Contractor shall have a process for evaluation of staff performance that includes a review of qualifications (i.e., an assessment of the employee's capabilities, experience, and satisfactory performance), reports of complaints received including resolutions, corrective actions taken, and supports provided to improve practice and to continue to monitor the staff evaluation process.

Credentialing Requirements

CAMHD is committed to ensuring that staff is competent and qualified to provide the intervention/services to students/youth as evidenced by meet the following departmental credentialing requirements.

Credentialing requirements apply to all individuals providing direct services including subcontractors of a Contractor. All Contractors shall have written policies and procedures that reflect their responsibility to credential and re-credential their direct care staff, sub-contracted individuals, and clinical supervisory staff prior to provision of services. Contractors shall be guided by CAMHD's credentialing policies and procedures in developing their policies and procedures. Primary sources of information shall be verified by Contractors as a function delegated by CAMHD.

CAMHD Care Coordination

All CAMHD youth have their services coordinated by a care coordinator to ensure timely, appropriate and coordinated service delivery.

The Care Coordinator (CC) is the case manager who is responsible for engaging the youth and family and assisting parents with coordinating the youth's education, health care and mental health services. Parent Partners are also available to provide peer support to parents in this regard. CCs are responsible for referring the youth for appropriate CAMHD services, maintaining contact with the youth/family,

ensuring the timely and efficient delivery of quality services, and continuous monitoring of the effectiveness of interventions to assure that youth receive medically necessary care.

The CAMHD provides services and supports through an integrated public-private partnership consisting of contracted community-based agencies and state managed, community-based Family Guidance Centers, and a centralized state office to provide administrative and performance oversight functions. Most of the youth served by CAMHD attend public schools, and may be involved with the child welfare system, juvenile justice system, or other Dept. of Health divisions, including the Alcohol & Drug Abuse Division, Developmental Disabilities Division, and Early Intervention Services. A large percentage of the CAMHD population in QUEST Healthplan (Medicaid) services, which requires linkages to primary care providers. The CAMHD system is committed to working with all other child-serving agencies to integrate services and programs across agencies in the best interest of the youth and their families.

Mental health services provided within the CAMHD system are expected to be evidence-based. Interventions with youth are meant to incorporate elements of those treatments identified as most promising based on credible scientific data. CAMHD's array of services provides a medium through which evidence-based interventions can be applied at high levels of intensity and in a variety of settings, depending on the needs of the youth. CAMHD regularly reviews, summarizes, and disseminates relevant research data to support agencies in their selection and implementation of services.

Training

There have been a number of training CAMHD events, particularly on Neighbor Islands, about cross-agency collaboration. Jenny Wells, a Special Educator for UH, was invited to conduct training on better agency communications. People from communities were brought together to identify where they experience difficulties in their collaborative efforts, and how they have overcome obstacles. One such training resulted in a resource fair being held on Kauai. Trainings in Hilo have resulted in community discussions around crisis services.

The system of care grant, Project Laulima, organized a professional learning community, a training project with about 50 professionals from a wide range of agencies and disciplines who are learning about youth with co-occurring mental health and intellectual disabilities. The training was provided by the Center for Start Services, national experts on co-occurring disorders. This initiative was an effort to increase the knowledge of the workforce around these issues by educating mental health providers about youth with developmental disabilities/mental health challenges. Participants included CAMHD providers including the Comprehensive Behavioral Intervention (CBI) providers, Hawaii Youth Correctional Facility Social Workers, Special Ed, UH Faculty, Developmental Disabilities Division, and CAMHD Family Guidance Center staff. The Hilo area has a deep need, so many of the learning community participants are from Hilo.

CAMHD's Summer Conference with Pat Miles provided training on strengths-based work with families, and family engagement. CAMHD's clinical staff, including Clinical Leads, Care Coordinators, Mental Health Supervisors, and Family Guidance Center Chiefs were able to attend and take advantage of the training. In 2015, CAMHD conducted training for all Care Coordinators on targeted case management and working as part of a clinical team.

Hawaii's state funded, community-based children's mental health system of care

Due to a state lawsuit (Felix v. Waihee), the Hawaii Department of Health was able to develop a comprehensive community-based children's mental health system through funds provided by the Hawaii State Legislature. Hawaii's children's mental health services are delivered in the youth's community through CAMHD's six geographically-defined Family Guidance Centers and satellite offices. Hawaii does not institutionalize youth in state-run mental health hospitals. CAMHD has a full array of services funded by state dollars, a portion of which is reimbursable through Medicaid. CAMHD has never used federal funds to supplant state funds.

Mental Health Block Grant Plans

Mental health block grant investments will be made in direct services in an amount of at least 10% of the total funds to provide evidence-based services to address the needs of individuals with early serious mental illness; services to homeless youth and their families, many of whom are Native Hawaiian who live on beaches and in cars in a rural area of the state; targeted gender-specific services for girls with histories of trauma; and to help address a long-standing gap of clinical expertise on the east side of the Big Island.

With the new set-aside requirements, Hawaii started an evidence-based Coordinated Specialty Care program for youth and young adults with First Episode Psychosis. After the first few years focused on the development of the program and protocols and the hiring and training of staff, Hawaii now has a fully operational program. At this point in time, the program is on the verge of opening a clinic in a building on the property of a major shopping mall. The mall is a major hub for the bus lines, and is frequented by international and mainland visitors, as well as local residents. We are pleased that the popular location will help to increase accessibility and ease the stigma of receiving services. The next few years will be devoted to developing the Electronic Health Record and its interoperability with the state's electronic health record system, and building more robust programming, such as vocational services, independent living and after care services.

MHBG funding will be used to provide targeted services to a rural, homeless population on the Waianae Coast on the island of Oahu. The Waianae Coast is a rural community of predominantly Native Hawaiians. A trauma-trained Social Worker provides individual, group and family therapy to the homeless children and their families. Eligible children have symptoms of mental illness that meet diagnostic criteria and affect their functioning in school and community. Typically, the children exhibit problems in emotion and behavior, and those issues are often related to attachment disorders, trauma and maternal depression. Parents and teachers report difficulties in dealing with these challenging behaviors. Over the past year, 25 individuals were provided mental health crisis management services, 156 children were provided group counseling, 175 Native Hawaiian families were provided case management services, and over 300 children were linked to health and mental health services, educational services, medical care, nutrition programs, and housing services.

The system of care grant, Project Kealahou, was successful in developing effective strategies and services for young girls with histories of trauma. The children's mental health system will continue to provide those strategies and specific trauma-informed services with the help of the block grant. Kealahou Services, now proven to produce positive outcomes, is an evidence-based program that

addresses a previous gap in Hawaii's mental health services. Long has the children's mental health division offered evidence-based services that address externalizing behaviors, which are typically exhibited by males. Kealahou Services is the first set of services and strategies designed to address the internalizing behaviors typical of females.

There has been a long-standing shortage in clinical leadership and expertise on the east side of the Big Island. The Clinical Director position has been vacant for over 3 years. The Child & Adolescent Mental Health Division has had to be creative in filling that gap with telepsychiatry, air travel, and coverage by other staff and contracted providers. There are funds set aside from the block grant that will assist with providing coverage. Experienced staff will provide virtual reality coverage and/or in person.

Under Information systems, investments will be made in the development of epidemiological systems and data with the addition of an epidemiologist position to serve in an administrative capacity the Department of Health, Behavioral Health Administration to support clinical services. This position will be used to assemble demographic, outcomes, and other data to assess the needs, services and outcomes of behavioral health clients across all of the Behavioral Health Administration. These data will be used for many purposes, but especially to look at effectiveness of programs and needs of the larger community. The vision is that when gaps are identified, programming will be instituted to address them. The position will be jointly funded with contributions from Alcohol and Drug Abuse Division, Adult Mental Health Division and Child & Adolescent Mental Health Division.

Additionally under information systems, CAMHD has a contract with the University of Hawaii Department of Psychology to provide information technology and data systems development, data analysis and report writing. This valuable resource provides the systems support to measure outcomes and data to assure that quality services are provided in a timely, efficient and cost-effective manner.

CAMHD's Clinicians serve dual roles as administrative leaders and mental health clinicians. Clinical decisions and service authorizations that require high level approval need to be made quickly for clinical and financial reasons. We have found that text messaging clinical leaders otherwise engaged in meetings is an effective way to focus their attention on matters that need their immediate attention. CAMHD uses block grant funds to provide cell phone coverage to our highest level of clinical leaders for consultation and authorizations.

The Hawaii Interagency State Youth Network of Care (HI-SYNC) is a collaborative partnership among the child-serving agencies. Its monthly meetings include representatives from Child Welfare Services, Family Court, Developmental Disabilities Division, Alcohol and Drug Abuse Division, Early Intervention Services, the Children's Coordinating Councils Office, and Hawaii's statewide family organization. At the local level, district quality assurance teams meet monthly to review data and track improvement activities, while each "shared" child is reviewed at least quarterly. Annual case-based reviews are used to measure child status and system performance. A joint report, Hawaii Youth Interagency Performance Report (HYIPR) has already been issued. Currently, work is in process to formalize the working relationships into a new Memorandum of Understanding among HI-SYNC members. This MOU sets out that the agencies will share in the responsibility of funding a Coordinator to facilitate meetings,

discussions and track outcomes. Block grant dollars will be matched by the other agencies to fund the position.

	COMMUNITY MENTAL HEALTH BLOCK GRANT		BG #37 FFY2018 10/01/2017 - 09/30/2019
Direct Services	FIRST EPISODE PSYCHOSIS SET ASIDE	FEP - UH Psychology	\$279,367.00
		FEP – UH School of Medicine	\$26,172.00
		Total CAMHD FEP	\$305,539.00
	Direct-Service Activities	Catholic Charities - Homeless Mental Health	\$100,000.00
		Kealahou Services	\$355,772.00
		CAMHD Hilo Clinical Coverage	\$797.00
Non-Direct Services	Information systems	BHA Epidemiologist	\$25,000.00
		Data & Health Information Technology	\$220,000.00
	Infrastructure support	CFS - Family Support	\$0.00
		ZOOM	\$0.00
		Cell phone consultation	\$2,000.00
	Partnerships, community outreach, and needs assessment	HISYNC Coordinator	\$30,000.00
	Training and education	CAMHD Clinical Training	\$0.00
	Administration <5% (\$51,955)	State Council Parking	\$0.00
	TOTAL	Total Non-FEP Projects	\$733,569.00
	CAMHD FEP Total		\$305,539.00
	CAMHD Non-FEP Total		\$733,569.00
CAMHD BUDGET TOTAL		\$1,039,108.00	

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?

☐ Yes ☒ No

Does the state have any activities related to this section that you would like to highlight?

None at this time.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

NOT FINAL

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma⁶⁰ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁶¹ paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

61 Ibid

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ☐ Yes ☐ No
2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ☐ Yes ☐ No
3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ☐ Yes ☐ No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ☐ Yes ☐ No

5. Does the state have any activities related to this section that you would like to highlight.

The Adult Mental Health Division and the state operated Community Mental Health Center system are updating existing policies and procedures and have identified the need for additional education regarding therapy approaches.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁶²

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶³

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

⁶² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

⁶³ <http://csqjusticecenter.org/mental-health/>

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? ☐ Yes ☐ No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ☐ Yes ☐ No
3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? ☐ Yes ☐ No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? ☐ Yes ☐ No
5. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? j n Yes j n No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? j n Yes j n No
3. Does the state purchase any of the following medication with block grant funds? j n Yes j n No
 - a) ☐ Methadone
 - b) ☐ Buprenorphine, Buprenorphine/naloxone
 - c) ☐ Disulfiram
 - d) ☐ Acamprosate
 - e) ☐ Naltrexone (oral, IM)
 - f) ☐ Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? j n Yes j n No
5. Does the state have any activities related to this section that you would like to highlight?
This section will be covered in the Hawaii SABG 2018-2019 Block Grant Application.

Please indicate areas of technical assistance needed to this section.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

This section will be covered in the Hawaii SABG 2018-2019 Block Grant Application.

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.⁶⁴ SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁶⁵,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

⁶⁴<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶⁵Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please respond to the following items:

1. Crisis Prevention and Early Intervention

- a) ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) ☐ Psychiatric Advance Directives
- c) ☐ Family Engagement
- d) ☐ Safety Planning
- e) ☐ Peer-Operated Warm Lines
- f) ☐ Peer-Run Crisis Respite Programs
- g) ☐ Suicide Prevention

2. Crisis Intervention/Stabilization

- a) ☐ Assessment/Triage (Living Room Model)
- b) ☐ Open Dialogue
- c) ☐ Crisis Residential/Respite
- d) ☐ Crisis Intervention Team/Law Enforcement
- e) ☐ Mobile Crisis Outreach
- f) ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- a) ☐ WRAP Post-Crisis
- b) ☐ Peer Support/Peer Bridges

- c) ☐ Follow-up Outreach and Support
- d) ☐ Family to Family Engagement
- e) ☐ Connection to care coordination and follow-up clinical care for individuals in crisis
- f) ☐ Follow-up crisis engagement with families and involved community members
- g) ☐ Recovery community coaches/peer recovery coaches
- h) ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

The Adult Mental Health Division (AMHD) is currently working towards the implementation of a Honolulu Emergency Services and Jail Diversion Program-like (HEPSJDP) program for law enforcement support in Hawaii, Maui and Kauai Counties. The HEPSJDP also provides significant levels of mental health training for both new recruits at the recruit academy, as well as for all sworn police officers and 911 dispatch staff on an annual basis. These training efforts will be duplicated in each of the remaining counties when programs are in place. AMHD is also working to implement a crisis Respite program for Kauai County that will provide some crisis bed residential capacity targeted towards the level of need in that county.

Please indicate areas of technical assistance needed to this section.

Technical assistance is not needed at this time.

Footnotes:

NOT FINAL

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|---|--|--|
| • Clubhouses | Peer-run respite services | Whole Health Action Management (WHAM) |
| • Drop-in centers | • Peer-run crisis diversion services | • Shared decision making |
| • Recovery community centers | • Telephone recovery checkups | • Person-centered planning |
| • Peer specialist | • Warm lines | • Self-care and wellness approaches |
| • Peer recovery coaching | • Self-directed care | • Peer-run Seeking Safety groups/Wellness-based community campaign |
| • Peer wellness coaching | • Supportive housing models | • Room and board when receiving treatment |
| • Peer health navigators | • Evidenced-based supported employment | |
| • Family navigators/parent support partners/providers | • Wellness Recovery Action Planning (WRAP) | |
| • Peer-delivered motivational interviewing | | |

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ☒ Yes ☐ No
- b) Required peer accreditation or certification? ☒ Yes ☐ No
- c) Block grant funding of recovery support services. ☒ Yes ☐ No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

The Adult Mental Health Division (AMHD) encourages all consumers and their family members to participate in trainings on self-determination, self-advocacy, and peer provided services, Wellness Recovery Action Plan (WRAP) planning and leadership development to reach their goal of independence and to direct their own recovery both within and, eventually, outside the public mental health system of care. Services that support consumers in their recovery include: Recovery (Treatment) Planning; Clubhouse Services (including Supported Employment); Work Incentives Training; and Peer provided supports (Peer Coaching, Peer Specialists and Peer Educators).

The AMHD's priority is to continue to implement and refine an integrated, consumer-centered, recovery-based behavioral health system that provides culturally informed and evidence-based treatment and services. AMHD has developed activities for consumers including, but not limited to, participation in one's treatment plan, as well as a provision of recommendations and comments relative to review, planning, and evaluation of services. These concepts and values of self-determination, which emphasizes participation and achievement of personal control for individuals served through the public mental health system also applies to adults who are experiencing homelessness. These concepts and values stem from a core belief that individuals who require support through the AMHD system have the freedom not only to define the life they seek, but to be directly supported with assistance they require in pursuit of that life.

The AMHD system's guiding principles are:

- Hope. Each person with SMI has the potential for growth and change;
- Purpose. Each person with SMI has the potential to realize a positive self-image and purpose;
- Acceptance. SMI illnesses are generally life-long with an individualized course of recovery which may include relapse and remission;
- Responsibility. Recovery is founded on self-mastery. This includes an understanding of the disease or disorder and skills needed to prolong remissions and shorten relapses; and
- Mutual Help. Each person's personal experience in recovery is a critical aid to help oneself and others.

The Child and Adolescent Mental Health Division (CAMHD) values the input of families and youth in the design and evaluation of the system. CAMHD has committed to the family voice by contracting with a Family Support Organization. The Parent Partners of that organization are persons with lived experience of being a parent/grandparent/foster/hana'i (Hawaiian cultural adoption into the family) of children with social, emotional and/or behavioral challenges. Parent Partners are recruited from the very communities they will serve. The Parent Partners are assured seats and a voice in governance at the community-based Family Guidance Centers and with CAMHD's top administration. It is through the insight of their lived experiences that we are able to provide services in a manner that best meets the needs of youth and their families.

2. Does the state measure the impact of your consumer and recovery community outreach activity? ☒ Yes ☐ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

ADULT SERVICES

In the adult system, the planning process is based on multiple mental health professionals' assessments, is consumer focused and culturally informed, and incorporates the consumer's strengths and recovery goals & preferences. The recovery planning process begins as early as intake and ideally occurs in every meeting between the consumer and a recovery team member leading up to (and proceeding from) each Master Recovery Plan meeting, so that the meeting can be as comprehensive and efficient as possible. The planning process identifies and describes the consumer's strengths and goals, behavioral challenges and needs, and prioritizes identified needs. It establishes measurable long/intermediate and short term goals as appropriate, identifies approaches or interventions based on identified strengths and facilitates consumers meeting those goals. The Recovery Plan

review evaluates the consumers' progress toward those goals on identified target dates throughout the course of care.

Review of each consumer's Recovery Plan occurs at least once every six months, or whenever there is a significant change in it (e.g. change in problem identification, focus of treatment, level of care, or services provided, such as Crisis Mobile Outreach contact), and are structured to maximize consumer, family and community involvement. Further examples of triggers for revision of Master Recovery Plan include: suicide attempt, Emergency Room visit; significant clinical change; homeless or immediate risk of losing housing; at risk of revocation of conditional release order; loss of significant member of consumer's support system; decreased or no treatment participation; and substance use relapse.

CHILDREN'S SERVICES

For youth, it is the policy of the children's mental health division to engage, welcome, support, inform and empower family members so that they can participate effectively in the mental health treatment of their child. The state provides families with information about evidence-based services and best practice guidelines to support decision-making about the treatment options available for their child. Children's mental health seeks to include the family perspective in decision-making at all levels of its operations and regularly assesses family engagement needs at the individual team level, the Family Guidance Center level, and at the State level. Hawaii Child and Adolescent Service System Program (CASSP) Principles guide the state's operations. The children's division assures the provision of the family voice in its governance.

Family Engagement Standards:

- A. Family member involvement will be sought early and sustained throughout their child's treatment process.
- B. The family member will be given the information they need in a form they can understand in order to participate in treatment and planning.
- C. CAMHD will be respectful and supportive of family members' culture and linguistic practices and use a strengths-based approach in partnering with families.
- D. CAMHD will regularly seek input and feedback from the family member to help guide clinical practices.
- E. A Parent Partner will be available to support and assist the family members.
- F. CAMHD will provide care that is transparent and accountable to family members.
- G. CAMHD will work to engage family members throughout the treatment process from the pre-treatment phase through discharge.

CAMHD has streamlined the intake process and made it more family friendly and more consistent across all Family Guidance Centers. This was in anticipation of the new data system that has a better way of handling forms and getting it into electronic health record. CAMHD will be able to track data, like how long it takes from the time parents apply for services until they get services, and the rate of "failed intakes". It is not unusual for CAMHD to open a case, go through the intake process and then the families fail to come back. If we can get better data of when that's happening, then we'll be able to show better engagement. CAMHD has evidence of increased rates of Ohio scales administration. The Ohio Scales assess outcomes in functioning, satisfaction, hopefulness, problem severity and restrictiveness of living. The forms are completed by the youth, caregivers and service providers, which provides the perspectives of the various team members. Monthly Progress Noting by care coordinators may be improving, which would show that they're seeing families regularly and documenting it. All these improvements are designed to include families as participating members of the treatment and recovery process.

In order to assure the availability of robust peer support for families, and ensure parent input into CAMHD programs and policies, CAMHD developed a new Request for Proposals (RFP) for a Family Support Organization to provide Peer Support services to caregivers statewide in the Fall of 2015. This has led to the selection of a new provider. Child & Family Service of Hawaii's new Ohana Program provides Parent Partners in each of CAMHD's Family Guidance Centers and works to ensure that they are all certified by the National Federation of Families to provide Peer Support Services. CAMHD is working with MedQUEST Division to make it possible to obtain Medicaid reimbursement for these services. This should help assure the sustainability of these family supports.

Community Outreach

CAMHD facilitates on-going community events and utilizes various outreach strategies to ensure that families in the larger community can access intensive mental health services for their children when they are needed. Through a partnership with the University of Hawaii, a website "Help Your Keiki (Child)" was developed to provide easy-to-understand mental health information to parents and others in an effort to increase education and demand for evidence-based mental health services.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Recovery Supports for Individuals with Substance Use Disorders

A cornerstone of the recovery concept is the active participation of consumers in all avenues of the service system supporting the growth of independence and empowerment that leads to consumer recovery. Many adults with serious mental illness have a co-occurring alcohol or substance use diagnosis. This co-morbidity complicates the care and treatment of their mental illness. Therefore, the Community Mental Health Center (CMHC) system has implemented an Integrated Dual Diagnosis (IDDT) treatment approach, and maintains a close working relationship with addiction service providers in the community. The IDDT model is an evidence-based practice in which practitioners address mental health and substance use disorders at the same time within the same setting, which creates better outcomes and lowering relapse rates. The treatment is multidisciplinary and combines psychiatric medication management, psychological therapies education, and life skills training. Each of the CMHC has a Substance

Abuse (SA) Specialist who assist with coordination or direct provision of services to persons in need, identifies and maintains prevalence data and assists with ensuring the embedding of integrated substance abuse services by participating in quality assurance activities. The Clubhouses usually address substance use issues with consumers, although not formally, but they support the other services provided to co-occurring consumers in their recovery.

In general, most of the Community Mental Health Centers provide co-occurring mental health and substance use disorder treatments including individual counseling. There are standing groups that have monthly meetings, such as the dual diagnosis groups, relapse prevention groups and other drug-specific groups such as, the Methamphetamine Users Group. Psychoeducation is provided along with group cognitive-behavioral counseling interventions designed to enhance management of co-occurring disorders. There are gender specific Seeking Safety groups for women with co-occurring trauma and substance issues. In addition to the CMHC system, the AMHD also contracts Po'ailani, Hina Mauka, and Aloha House in the provision of residential treatment for co-occurring disorders.

For inpatient services at the Hawaii State Hospital, within seven days of a patient's admission to the hospital, a screening/assessment is completed. This screening/assessment is based on the patient's interview (substance use issues), behavioral observation, review of the clinical record (written or electronic) and interviews from family members and collateral sources (based on case manager, probation officer's input). This process takes approximately 25 days from admission. If the assessment is over one year old, a new assessment is generated. After the assessment is completed, the SA Specialist creates treatment goals in a Master Recovery Plan with the appropriate goals and interventions based on the patient's stage of change.

5. Does the state have any activities that it would like to highlight?

None at this time.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not needed at this time.

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

housing services provided.	<input type="checkbox"/> Yes <input type="checkbox"/> No
home and community based services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
peer support services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
employment services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the state have a plan to transition individuals from hospital to community settings? ☐ Yes ☐ No
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The Adult Mental Health Division serves as the State Mental Health Authority (SMHA) and is responsible for the Readmission Screening and Resident Review (PASRR). Under the PASRR program, the Medicaid statute prohibits nursing facilities from admitting any individual with a serious mental illness, unless the SMHA has determined that the individual requires the level of services the facility provides. By using the PASRR screening tool, individuals are not inappropriately placed in nursing facilities, and the individuals are also transitioned into community-based settings.

Does the state have any activities related to this section that you would like to highlight?

In 2016, the Department of Health's Adult Mental Health Division through its Office of Consumer Affairs held five consumer conferences across the islands. More than 250 persons with serious mental illness attended the conferences. The conferences included a session about recovery, and there were group discussion topics about how to achieve recovery.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community⁶⁶. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24⁶⁷. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death⁶⁸.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21⁶⁹. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs⁷⁰.

According to data from the 2015 Report to Congress⁷¹ on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

⁶⁶Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁷Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁶⁸Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁶⁹The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁷⁰Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMH12010>

⁷¹ http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? ☐ Yes ☐ No
 - The recovery and resilience of children and youth with SUD? ☐ Yes ☐ No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
 - Child welfare? ☐ Yes ☐ No
 - Juvenile justice? ☐ Yes ☐ No
 - Education? ☐ Yes ☐ No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? ☐ Yes ☐ No
 - Costs? ☐ Yes ☐ No
 - Outcomes for children and youth services? ☐ Yes ☐ No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ☐ Yes ☐ No
 - Mental health treatment and recovery services for children/adolescents and their families? ☐ Yes ☐ No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult behavioral health system? ☐ Yes ☐ No
 - for youth in foster care? ☐ Yes ☐ No
- Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

INTEGRATED SYSTEM OF CARE

Three major state agencies - the Child and Adolescent Mental Health Division (CAMHD), the state Department of Education, and the Med-QUEST Division of the Department of Human Services - jointly provide for a comprehensive community-based system of care for children and adolescents in need of mental health services in Hawaii. The services of each agency and CAMHD's collaborative and integrated partnerships with these agencies are described below.

DEPARTMENT OF EDUCATION

Children and youth who have educational disabilities receive school-level supports and services through their home school. The school provides assessment and diagnostic services whenever concerns arise that children or youth have a disability that might affect their education. If indicated, the school provides classroom strategies and specific mental health services. If more intensive services than those available at the home school arise, the school arranges access to the CAMHD services.

Children and youth who are having emotional challenges that are not affecting their education receive mental health services from their family private insurance or a Department of Human Services Med-QUEST provider. The Med-Quest Health Plans provide medically necessary services for assessment and mental health treatment. If more intensive services than those available through the Medicaid Health Plan arise, the youth is referred to the CAMHD system.

Generally, the charge of the state education agency (SEA) is to monitor and enforce compliance with state and federal mandates, including IDEA, and to monitor and enforce compliance and to provide leadership and guidance through technical assistance to ensure that local educational programs are compliant and of high quality. Traditionally local education agencies (LEAs) provide the implementation of programming that leads to meaningful educational outcomes for students and their families. The Hawaii Department of Education performs the function of a local education agency (e.g., operating program services) while also maintaining oversight and technical assistance responsibilities as the state education agency. Hawaii's public schools form a single, statewide district that spans six islands and seven geographic districts: Central, Honolulu, Leeward and Windward on Oahu; and Hawaii, Maui (including Molokai and Lanai islands) and Kauai (including Niihau Island). Each complex consists of a high school and the elementary and intermediate/middle schools. There are 287 public schools, 31 of which are charter schools.

Aligned with IDEA legislation, Hawaii public schools offer a continuum of alternative placements where students receive special education or related services, including regular classes, special classes, special schools, home instruction and instruction in hospital settings. With the 2004 IDEA reauthorization, Hawaii added a provision for supplementary services such as a resource room or the provision of itinerant instruction in the regular classroom placement. Hawaii's education system takes great effort to provide special education and related services at the student's neighborhood or home school.

Hawaii's Department of Education (DOE) incorporates a Comprehensive Student Support System (CSSS) to meet the academic, physical, social, and emotional development of all of its students. The CSSS responds to student needs that may correspond to one of five levels: 1) basic support for all children, 2) informal support through collaboration, 3) services through school-level and community programs, 4) specialized services from DOE and other agencies, and 5) intensive and multi-agency services. Students whose needs are at level 4 may receive special education services or services through the School-Based Behavioral Health (SBBH) program.

School Based Behavioral Health (SBBH) provides evidence-based mental and behavioral health interventions to students with the most challenging mental and behavioral health concerns when it impacts their learning or the learning of others. SBBH program staff includes Behavioral Specialists, School Counselors, School Social Workers, Clinical Psychologists, and School Psychologists, who are located within schools/complexes. They assist school teams in understanding students' challenging behaviors and disabilities and in developing strategies and supports to help students benefit from their education. Parents, as members of the IEP/MP teams, participate in developing the IEP/MP goals and objectives, Functional Behavioral Assessment and Behavioral Support Plans. School teams (IEP and MP), work collaboratively with other SBBH program staff (School Psychologists, Clinical Psychologists, Mental Health Supervisors, School Social Workers, and Psychological Examiners) to properly address the student's functioning and develop classroom strategies as well as behavioral supports and interventions. CAMHD's geographically located Family Guidance Centers roughly correspond with the DOE districts.

Positive Behavior Supports Program. The Positive Behavior Supports Program develops local capacity at individual schools to:

- develop proactive behavioral practices,
- use school discipline as an instrument for student success,
- formalize team-based problem solving for addressing behavioral concerns and challenges,
- develop a continuum of procedures for acknowledging appropriate behaviors,
- develop a continuum of procedures for discouraging inappropriate behaviors,
- have on-going monitoring and evaluation procedures, and
- develop the local expertise and capacity of the school leadership team to address simple to complex behavioral challenges of students.

Primary School Adjustment Project (PSAP). The Primary School Adjustment Project is a school-based early identification and intervention program which seeks to enhance learning and adjustment skills to reduce social, emotional, and school adjustment difficulties for children in grades kindergarten through three. It is a preventative mental health project based on the belief that early intervention can prevent the development of more serious difficulties in later years

Community Children's Councils (CCC). The Community Children's Councils were created in the Felix Implementation Plan as one of the key partnerships in the development of a full array of services to special needs children and their families. The mission of the CCC is to provide local forums statewide for all community members to come together as equal partners to discuss and positively affect multiple systems issues for the benefit of all children, families, and communities. Full participation of families is a high priority for the CCCs. They are led by parent and professional co-chairs and include representation from public and private child serving agencies, private providers, and other community members such as recreational services, businesses, churches, and others.

The purposes of the CCCs are to:

- function as community-based planning and evaluating groups
- provide support and training to parents of special needs children
- provide solutions to concerns raised by community members or refer to proper authority for resolution

- identify any gaps in service delivery and offer possible solutions
- provide feedback to policy makers regarding the effect of policies on service delivery in the local community
- provide system advocacy activities to support, sustain and maintain the quality of services needed in the local community
- serve as a direct link to the Departments of Education and Health and other child serving agencies regarding consumer and community satisfaction

There are 17 CCCs in Hawai'i (8 on Oahu, 4 on Maui, 4 on Hawai'i Island, 1 on Kauai) who usually meet once a month. Parent support groups, workshops, and informational meetings on pertinent subjects are common local activities. Conferences and special events are offered throughout the year.

IDEA is a federal law that ensures that students who require specially designed instruction to meet their unique learning needs due to a qualifying disability (e.g., Specific Learning Disability, Emotional Disability, etc.) are given an Individualized Education Program (IEP) and related service, if needed, to benefit from special education as appropriate. SBBH counseling can be considered one of those related services. During 2014-15, a total of 4,962 students identified as IDEA received Counseling or other SBBH services within the DOE.

Section 504 of the Rehabilitation act of 1973 is a federal civil rights law that protects students with a disability from discrimination, as well as ensures the same equal opportunity and access to educational opportunities to qualified students as are provided to students without disabilities; identified needs must substantially limit a major life activity and impact a student's education. Section 504 requires that students with disabilities are provided appropriate educational services designed to meet the individual needs of such students to the same extent as the needs of students without disabilities are met; SBBH counseling could be considered a supplementary service and may be listed on their Modification Plan (MP). During 2014-15, a total of 1,223 students identified as IDEA received Counseling or other SBBH services within the DOE.

Special Education (SpEd) is specially designed instruction and related services to meet the unique needs of eligible students with disabilities under the IDEA/Chapter 60. Services include academic services, speech-language services, psychological services, physical and occupational therapy, and counseling services. The Department provides these services at no cost to families to students aged 3 to 22 who demonstrate a need for specially designed instruction.

The CAMHD has developed a more collaborative model in working with the Department of Education to facilitate early identification of CAMHD-eligible youth. In 2015, for example, several high-profile cases that required coordination of mainland behavioral health placements demonstrated the need for coordination between CAMHD and the DOE. We have remodeled the process for these placements and shortened the timeframe by one half. This required coordinated planning from DOE and DHS. DOE has agreed to pay for educational charges for all placements, no matter the requesting agency. Out of this process has grown a formalized one-to-one accountability between the CAMHD Administrator and a Deputy Superintendent of the DOE. Policy problems will be handled at this level. The Deputy Superintendent will be a standing member of Hawaii Interagency State Youth Network of Care (HI-SYNC) which will assure decision making power on this multi-agency forum.

DEPARTMENT OF HUMAN SERVICES

The majority of Hawaii's children have access to health coverage. In 2013, 92.7 percent of eligible children participated in MedQUEST or Quest, Hawaii's Children's Health Insurance Program (CHIP). In 2013, a total of 138,258 Hawaii children ages 0-18 were enrolled in MedQUEST, and 30,979 in Quest. However, more than 9,000 children ages 0-17 (3% were uninsured in 2013). The state had the 2nd lowest uninsured rate among states. (Children's Defense Fund, Children in the States – Hawaii, September 2015).

The Med-QUEST Division of the state's Medicaid Agency (Department of Human Services), contracts with health plans to provide health services to the Medicaid eligible population. The health plans provide medically necessary mental health assessments and treatment services to children and youth. Since 1994, CAMHD has had a Memorandum of Agreement with the Med-QUEST Division that provides that CAMHD serve the Medicaid eligible SEBD (Support for Emotional and Behavioral Development) youth. In 1999, the Memorandum was modified to include services to all youth who are eligible under Hawai'i's Felix Consent Decree and who are Medicaid eligible. Med-QUEST identifies children and youth who are SEBD eligible and refer the youth to CAMHD for intensive care coordination and access to CAMHD's comprehensive array of community-based services.

Hawaii Children's Insurance Program. Hawaii's free public health insurance programs are QUEST and QExA, managed by the Department of Human Services. For children and youth to be eligible, they must be 0 to 19 years old, meet household income level up to 300%, and qualify as U.S. citizens, lawful permanent residents, refugees, or citizens of the Marshall Islands, Federated States of Micronesia, or Republic of Palau. Covered services include regular check-ups, emergency care, immunizations, prescription medicines, doctor visits, eyeglasses, counseling and dental care. A child is covered for one year if he or she stays in the household and doesn't get other health insurance.

The Child Welfare Services Branch (CWSB) provides services to children and their families when the children are reported to have been abused and/or neglected, or to be at risk for abuse and/or neglect. These services include child protection, family support, foster care, adoption, independent living, and licensing of resource family homes, group homes, and child placement

organizations. CWSB is implementing four Title IV-E Waiver Demonstration Project initiatives on Oahu and Hawai'i Island to further safely reduce the number of children in foster care as well as time spent in foster care.

CAMHD is a key participant in the Child Welfare Service Branch's Safety, Permanency and Wellbeing (SPA) and Wraparound programs. SPA and Family Wrap Hawai'i are two strategies that the CWSB is implementing to decrease time in foster care, and increase permanency for children in foster care 9 months or longer. These multiagency collaborations are aimed at establishing permanency for children where permanency has been a significant challenge.

DEPARTMENT OF HEALTH

Early Intervention Services. The Department of Health, Family Health Services Division, Early Intervention Section (EIS) provides services for children from birth to three years of age with special needs. Early Interventionists assist children in the following five developmental areas: Communication (talking, understanding), Cognitive (paying attention, solving problems), Physical (sitting, walking, picking up small objects), Social or Emotional (playing with others, having confidence), Adaptive (eating, dressing self).

The Alcohol and Drug Abuse Division (ADAD) provides leadership in the development and delivery of quality substance abuse prevention, intervention and treatment services for the residents of Hawaii. ADAD's treatment efforts are designed to promote a statewide culturally appropriate, comprehensive system of services to meet the treatment and recovery needs of individuals and families. ADAD is the primary and often sole source of public funds for substance abuse treatment. ADAD's services are provided by a network of providers throughout the state.

The Developmental Disabilities Division (DDD) provides supports and services for persons with intellectual and/or developmental disabilities, which includes principles of self-determination and incorporates individualized funding, person-centered planning, and services provided in homes and in the community. DDD services are provided primarily through the Medicaid 1915(c) Home and Community Based Services Waiver.

Project Lualaba (Many hands working together)

The Child & Adolescent Mental Health Division applied for a system of care grant to develop more integrated and comprehensive services to children and youth with co-occurring mental health needs and developmental disabilities. Project Lualaba works to improve access and service quality. The Project brings together the Developmental Disabilities Division and Child and Adolescent Mental Health Division of the DOH, the Department of Education, the Department of Human Services, and several family and youth organizations to improve collaboration and coordination to meet the multi-agency needs of children and youth with both mental health needs and developmental disabilities. Project Lualaba focused on the development of new policies and programming, providing service accountability, capacity building, workforce development, and comprehensive training initiatives.

Child and Adolescent Mental Health Division (CAMHD)

CAMHD provides services to youth who a) have been certified as qualifying under the Individuals with Disabilities Educational Act (IDEA) for special education services and who are in need of related mental health services to benefit from their free and appropriate public education; and b) youth who meet the eligibility requirements for CAMHD's Support for Emotional and Behavioral Development (SEBD) program.

Through its 7 Family Guidance Centers and a Family Court Liaison Branch, CAMHD provides case management services to youth and families through the state through the assigned Care Coordinator.

Community-based Family Guidance Centers

CAMHD's community-based Family Guidance Centers (FGCs) are responsible for providing high quality, culturally competent, evidence-based treatment services to eligible children and adolescents. The FGCs are strategically located in geographic areas that correspond with the Department of Education school districts. Three FGCs are located on Oahu, where close to 72% of the state's population reside. Also, there is one FGC each on the rural neighbor island counties--Kauai, Maui, and the Big Island, with partial coverage for the islands of Molokai and Lanai. Most of the FGCs also have satellite offices. The geographic placement of FGCs and their satellite offices help to address the needs of Hawai'i's ethnic and racial diversity, which differs by geographic location.

Each FGC is led by a Center Chief, and is staffed with a psychiatrist, one or more psychologists, a quality assurance specialist, a fiscal officer, and social workers and mental health care coordinators to provide intensive case management. Services provided by the centers include clinical team management, intensive case management, direct service provision, authorization for contracted services, and utilization and quality monitoring. The FGCs work in partnership with youth and their families to design and implement individualized service plans.

The Family Court Liaison Branch (FCLB) provides screening, assessment, evaluative, diagnostic, treatment, and consultative services to youth with mental health challenges in the state juvenile justice system. FCLB provides mental health treatment linkages between the Family Court, Hawai'i Youth Correctional Facility, and the State's Detention Home. The FCLB works in partnership with families and the court system to design and implement individualized service and treatment plans suitable to the specialized needs of children and youth involved with the Hawai'i juvenile justice system. FCLB differs from CAMHD's other branches because

it does not have a geographical limitation, and provides direct services in collaboration with other state agencies and Family Court. FCLB staff spends considerable time and effort in conducting mental health assessments of youths at the direction of Family Court judges and in advocating for treatment of such youth in less restrictive settings, where appropriate.

Individualized care planning for children/youth with serious mental health disorders

Each youth's treatment is directed by a service plan that supports the use of medically-necessary evidence-based interventions in the least restrictive environment. CAMHD service planning is an individualized and ongoing process that is youth-guided and family/guardian centered.

Coordinated Service Plan (CSP). The Coordinated Service Plan identifies the specific strategies that will achieve broadly defined goals for the youth and family, and integrates strategies across the many agencies involved. The CSP process builds upon the strengths of the youth and family and requires the full engagement and involvement of youth, family/guardian, and key individuals involved in the youth's life including existing or potential service providers. Its purpose is to coordinate efforts across public agencies and other supports and services.

Mental Health Treatment Plan (MHTP). CAMHD's contracted providers are responsible for the development, implementation, review, revision and adjustments to the MHTP. The MHTP should be individualized for each youth and should be developed through a collaborative process driven by the family/guardian and youth that includes the contracted provider, family, and assigned CAMHD Mental Health Care Coordinator. The MHTP will identify evidence-based treatment interventions that are the most promising options for meeting a youth's individual goals and objectives.

CAMHD's comprehensive service array is comprised of a spectrum of effective, community-based services and supports:

- Mental Health Evaluation
- Psychological Testing
- Psychosexual Assessment
- Psychiatric Evaluation
- Medication Management
- Individual Therapy
- Group Therapy
- Family Therapy
- Multi-Systemic Therapy (MST)
- Functional Family Therapy (FFT)
- Intensive In-Home Therapy
- Intensive In-Home Paraprofessional Support
- Transitional Family Home
- Community-Based Residential, Levels I, II and III
- Partial Hospitalization
- Hospital-Based Residential
- Respite Supports
- Therapeutic Respite Home
- Intensive Independent Living Skills
- Independent Living Skills Paraprofessional Support
- Ancillary Services
- 24-Hour Crisis Telephone Stabilization
- Crisis Mobile Outreach
- Therapeutic Crisis Home

CAMHD Care Coordination

All CAMHD youth have their services coordinated by a care coordinator to ensure timely, appropriate and coordinated service delivery. The Care Coordinator (CC) is the case manager who is responsible for engaging the youth and family and assisting parents with coordinating the youth's education, health care and mental health services. Parent Partners are also available to provide peer support to parents in this regard. CCs are responsible for referring the youth for appropriate CAMHD services, maintaining contact with the youth/family, ensuring the timely and efficient delivery of quality services, and continuous monitoring of the effectiveness of interventions to assure that youth receive medically necessary care.

The CC coordinates regular home visits, school visits, and community contacts as indicated in the Coordinates Service Plan (CSP). When appropriate, responsibilities also include coordination of care with Family Court, and Department of Human Services and other state and community agencies. The CC is responsible for facilitating the integration, coordination, and monitoring of behavioral health services across programs and domains and for communicating important clinical developments to the Branch Utilization Review Team. Contractors are responsible for coordination of services that are provided within their agency and regular communication about their services to the CC. Coordination and communication are particularly important in settings where there are multiple staff providing services for a youth. Contractors are also expected to coordinate efforts with the youth's school and community settings. Ongoing engagement, communication and coordination with families are a necessary practice as families are an integral part of the therapeutic process

Core Components of the CAMHD System

These core components underlie the values CAMHD strives to operationalize in its practices. The CAMHD expects the same commitment from contractors to support these components in their respective practices.

1. Commitment to the Hawaii CASSP Principles

CAMHD is committed to the CASSP Principles and expects the same commitment from contracted providers.

Respect for Individual Rights

Individualization

Early Intervention

Partnership with Youth and Families

Family Strengthening

Access to Comprehensive Array of Services

Community-based Service Delivery

Least Restrictive Interventions

Coordination of Services

2. Commitment to Interagency Collaboration & Coordination

CAMHD is committed to work with all other child-serving agencies to integrate services and programs across agencies in the best interest of youth and their families.

3. Commitment to Evidence-Based Practices

Mental health services provided within the CAMHD system are expected to be evidence-based. Interventions with youth are meant to incorporate elements of those treatments identified as most promising based on credible scientific data.

4. Commitment to Performance Management

The CAMHD is committed to ongoing evaluation of performance and the use of data to continue the development and management of the system as well as to improve provider development. Its performance management practices involve an extensive system for examining performance and using findings to make informed decisions about services and needed adjustments to program implementation.

5. Commitment to Access & Continuity of Care

The CAMHD has the belief that every child/youth is capable of recovery and resiliency. CAMHD seeks to promote individualized care which empowers youth and their families to achieve their goals, and maximizes their opportunities to live full lives in their own communities. The CAMHD is committed to the philosophy of providing treatment at the most appropriate and least restrictive level of care necessary for effective and efficient treatment to meet the youth's bio-psychosocial needs. We see the continuum of care as a fluid treatment pathway, where youth may enter treatment at any level and be transitioned to more or less intensive levels of care as their changing clinical needs dictate. At any level of care, such treatment should be individualized and should take into consideration the youth's stage of readiness to change and participate in treatment.

7. CAMHD Clinical Model

To ensure appropriate, effective and efficient treatment, CAMHD maintains clinical oversight of each youth served. Each youth is assigned a Care Coordinator who will facilitate the planning, coordination of services and monitoring of treatment through consultation with the Branch Clinical Lead.

Each youth will be assigned a "Clinical Lead" – either a CAMHD psychologist or psychiatrist - who will oversee their care and authorize services. The Clinical Lead provides clinical direction of the treatment provided to youth through their collaboration and consultation with the youth's assigned Care Coordinator.

Each CAMHD branch Utilization Review (UR) Team includes all supervisory clinical staff (Clinical Psychologist, Child Psychiatrist, and Mental Health Supervisors) and the branch Quality Assurance Specialist. The role of the UR team is to assure that there is a clear clinical rationale for continuing the service and that all continuing stay criteria are being met.

CAMHD has established thresholds for the appropriate and effective length of stay for each service. CAMHD analyzed its data and determined the time frames in which the majority of youth showed maximum improvement. These time frames serve as the threshold for which a second level of review is needed in order to continue the service, since only a minority of youth showed continued improvement beyond this point in time.

Child and Adolescent Mental Health Performance Standards

In order to assure high quality services, CAMHD has invested heavily in developing comprehensive Performance Standards and Policies and Procedures that CAMHD staff and providers must all follow. The Child and Adolescent Mental Health Performance Standards (CAMHPS) is a manual developed by CAMHD for use in the development and provision of behavioral health services for youth. The standards and guidelines define service content standards and assure the efficiency and effectiveness of services. The CAMHPS Manual covers 32 pages of General Performance Standards and 156 pages of Service Specific Performance Standards. The Child and Adolescent Mental Health Performance Standards can be found at:

<http://health.hawaii.gov/camhd/files/2013/07/Orange-Book.pdf>

HAWAII'S INTEGRATED SERVICE SYSTEM

The Hawaii Early Intervention Coordinating Council (HEICC) is an advisory body that advises the Director of Health on issues related to the planning, implementation, evaluation, and monitoring of the statewide system of early intervention services, and assists the DOH in achieving the full participation, coordination, and cooperation of all appropriate public agencies in the state. Members are appointed by the Governor and include parents of children with special needs, early intervention providers, state legislators, and representatives for personnel preparation, special education preschool services, Medicaid program, Office of the Governor, provision/payment of early intervention services, Head Start/Early Head Start, child care, foster care, regulation of health insurance, education of homeless children, children's mental health, family advocacy, military, and community preschools.

In 1987, the Hawaii State Legislature passed a law that requires the establishment of an Interdepartmental Cluster for services to children in the Department of Health. The Cluster was to be comprised of representatives of all the major child-serving agencies with statewide authority and responsibility. Named in the law were the department of education, department of health, department of human services, the judiciary, the office of the governor and the office of youth services. The Cluster was tasked with coordinating services at the local level for the multisystem children with severe emotional and developmental problems. The Cluster later became known as the State Interagency Quality Assurance Committee. In 2015, the Committee was renamed the Hawaii Interagency State Youth Network of Care (HI-SYNC) to reflect the focus on youth outcomes. A few of the outcomes of the collaborative include a formal Memorandum of Agreement describing how the agencies will work together, an Interagency Consent Form, a Multidisciplinary Evaluation Team, and braided funding for a facilitator position. Additionally, HI-SYNC produces an annual report on performance outcomes for youth by the Developmental Disabilities Division, Family Health Services Division- Early Intervention Section, and Child & Adolescent Mental Health Division of the Department of Health; Special Education and School-Based Behavioral Health of the Department of Education; Child Welfare Services of the Department of Human Services; and Family Court of the Hawaii State Judiciary. The Hawaii Youth Interagency Performance Report (HYIPR) highlights each agency's population characteristics, service utilization, cost of services and performance outcome measures.

In 2014, the Hawaii juvenile justice system went through a major reformation. With the impetus of a report by the Pew Charitable Trusts that identified that too many youth were being held in confinement, the costs of confinement was steep and the results were poor, a working group was convened to make recommendations to address the issues.

The working group discovered that many areas of the state lacked effective community-based alternatives, leaving judges with few options to hold youth accountable and provide them with necessary services. Stakeholders highlighted the need for better access to mental health and substance abuse treatment, especially early in a youth's interaction with the juvenile justice system, and indicated that eligibility criteria—the standards used by an agency to guide service approval or denial decisions—made it difficult for youth to get treatment even where programs were available.

After five months of analysis, the working group produced a set of research-based, fiscally sound policy proposals. It recommended limiting placement in Hawaii's secure facility to more serious offenders; reinvesting the resulting savings in effective community-based options, specifically mental health treatment services; strengthening local supervision; and enhancing accountability in the juvenile justice system.

House Bill 2490, which contained the Working Group's recommendations was passed unanimously by the Legislature and signed into law in 2014. The law is projected to reduce the population in HYCF by 60 percent, enable the closure of two facilities on the HYCF campus, and produce savings of \$11 million in the facility's budget by 2019. It redirects the savings into effective community-based alternatives, and it also provides an upfront investment of \$1.26 million for mental health and substance abuse treatment, delinquency interventions, and implementation of the reforms.

With the passage of the law, the children's mental health division has been collaborating with the Judiciary and the Office of Human Services to streamline the referral process to enhance access to mental health services. The funding allows the children's division to provide needed services to those youth who would not otherwise be able to qualify for services based on their adjudicated standing.

MULTI-AGENCY COLLABORATIONS

CAMHD has built meaningful partnerships across systems to improve the child, youth and young adult functioning in home, school and community. A few of the collaborative efforts are highlighted here.

CAMHD's Project Laulima developed and implemented an interagency, Multi-disciplinary Evaluation Team ("MET"). The MET is a group of local highly-qualified professionals focused on providing comprehensive evaluation and consultation to children/youth with co-occurring mental health/intellectual or developmental disabilities and/or complex needs. MET members include professionals from multiple domains, representing several state agencies and community organizations such as the Department of Education, the Developmental Disabilities Division, the Child and Adolescent Mental Health Division, University of Hawaii -

Psychology and Special Education Departments and Shriners Hospital. The specific disciplines include educational/behavioral

psychology, child/adolescent psychiatry, developmental pediatrics, social work and pediatric neurology. HI-SYNC's MOU supports the participation of state workers from child-serving agencies on the MET. The MET recently 'teamed' around a multi-agency youth with complex needs. The team conducted a comprehensive record review, home and school visits and developed a list of suggestions and recommendations for the youth's treatment team.

A Memorandum of Agreement (MOA) with Office of Youth Services (OYS) allows CAMHD to serve youth who would otherwise be ineligible for services. For example, if Probation says a youth needs services but the youth is not Medicaid eligible, the MOA stipulates that OYS will cover the cost. For youth who are not yet deemed eligible, the MOA allows CAMHD to provide services to them while they are going through the Medicaid registration and SEBD (CAMHD eligibility) process. The MOA allows Probation to recommend CAMHD care instead of recommending something else.

Overall, as a state system, Hawaii is not incarcerating as many youth as before. The interagency MOA and interagency meetings are assisting with reducing the number of youth with mental health problems from being incarcerated. The down side is that, instead of youth getting locked up, CAMHD saw an increase in the number of youth being sent to the mainland concordant with this change. Nevertheless, Hawaii is heading in the right direction.

CAMHD sought and was awarded a system of care grant, Kaeru Services, to focus on returning youth from out-of-state residential treatment programs back to their home communities and prevent the future out-of-state displacement of youth. The program will utilize a combination of an intensive care planning process and a clinical intervention model. Implementing Kaeru Services will involve strengthening the infrastructure of the Hawai'i child-serving system so that it better exemplifies system of care principles. This will include a better integration of family and youth voice and choice at all levels of the system, increased cultural and linguistic competence, and improved interagency collaboration. The projected outcomes of this program include the successful return of youth placed in out-of-state placements; the reduction of future placements of youth in out-of-state care; a reduction in the cost resulting from fewer out of state placements; improvement in the delivery of clinical services and improvement in quality of life outcomes.

Hawaii Youth Correctional Facility (HYCF) started a Training Academy where all their staff undergo a rather extensive curriculum. CAMHD provides the mental health component of the curriculum. CAMHD trains all HYCF staff on a variety of mental health issues from a non-correctional perspective. The training includes Motivational Interviewing, suicide prevention, adolescent development, and trauma-informed care. CAMHD has participated three times in the Training Academies over the past two years.

CAMHD's therapeutic presence at Detention Home has been routinized. Previously, only referred youth were seen by a therapist, but now every youth is seen and has contact with a CAMHD Clinician.

A new development at the Judiciary's Home Maluhia Shelter is that CAMHD's Family Court Liaison Branch (FCLB) therapist now follow the youth home to provide continuity and may conduct family therapy.

CAMHD has a partnership with the Western Interstate Commission on Higher Education (WICHE) which provides interns at Detention Home who can provide therapeutic services, conduct psychological testing for underlying factors or things not covered under a regular evaluation, such as a personality inventory.

CAMHD screens every youth for emotional/behavioral/mental health problems that enters Detention Home or correctional centers. CAMHD meets every quarter with Family Court judges to discuss the intersection between mental health services and the juvenile justice system to address and resolve system issues.

CAMHD participates in a Statewide Interagency Workgroup that established a Statewide Protocol for addressing commercially sexually exploited children. Every agency--FBI, HPD, Judiciary, Child Welfare Services (CWS), Office of Youth Services (OYS) had their own protocols for sexually exploited youth. Then the protocols were collated into a master protocol that guides how the agencies work together. For example, at the front end, CWS uses a screening tool to identify trafficked youth and their protocol is to refer to CAMHD. Then CAMHD's protocol accepts the referral and provides trauma-informed care such as Trauma-Informed Cognitive Behavioral Therapy. Sex trafficked youth, from their own perspective, do not see themselves as such, and may believe they are in the usual boyfriend/girlfriend relationships. They do not self-identify as sex trafficked. The screening tool is hugely important in that it identifies whether the youth are being coerced or exploited.

CAMHD has developed aftercare for youth discharged from Benchmark (sexually reactive individuals), so they can have regular mental health contact to ease transition back to the community. CAMHD provides aftercare for up to 3 months and gets the youth connected to community services.

7. Does the state have any activities related to this section that you would like to highlight?

None at this time.

Please indicate areas of technical assistance needed related to this section.

No technical assistance need at this time.

Footnotes:

NOT FINAL

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ☒ Yes ☐ No

2. Describe activities intended to reduce incidents of suicide in your state.

The Emergency Medical Services and Injury Prevention System Branch (EMSIPSB) has led suicide prevention activities within the Hawaii State Department of Health since 2005 with support from the Child and Adolescent Mental Health Division, the Adult Mental Health Division, and the Alcohol and Drug Abuse Division.

EMSIPSB collaborates with the statewide Prevent Suicide Hawaii Task Force (PSHTF), a state, public and private partnership of individuals, organizations, and community groups working in suicide prevention. PSHTF members provide community leadership, develop strategies, coordinate activities, and monitor progress of suicide prevention efforts in Hawaii.

EMSIPSB, with the Injury Prevention Advisory Committee (IPAC) and other community partners, developed a 2012-2017 Hawaii Injury Prevention Plan (HIPP) that includes recommendations for suicide prevention that are based on the 2012 National Strategy for Suicide Prevention. Included in the plan are three recommendations for suicide prevention.

Recommendation 1. Develop and implement suicide prevention training for gatekeepers; Recommendation 2. Develop and implement a public awareness campaign; and develop Recommendation 3. Promote effective clinical and professional practices and policies.

The following are evidence-based initiatives and activities supported by HIPP:

EMSIPSB contracts with the University of Hawaii, Department of Psychiatry (DOP), to coordinate evidence-based suicide prevention trainings to a broad audience that includes the Department of Education and other youth serving organizations, public and private entities, health care providers, military, and community members. The primary suicide prevention trainings include safeTALK (Tell, Ask, Listen, Keep Safe), Asist (Applied Science Intervention Skills) Connect, Youth Mental Health First Aid, and Mental Health America Hawaii "Youth Suicide and Bullying Prevention" training.

Public Awareness - Major public awareness activities include: a bi-annual Suicide Prevention Conference; a Prevent Suicide Hawaii "Healing After" Conference to bring together a community of survivors, advocates, educators, policymakers, and health professionals around the issue of suicide; International Survivors of Suicide Mini-Conferences; and the American Foundation for Suicide Prevention Hawaii "Out of the Darkness" community and campus walks to fight suicide. Activities during Suicide Prevention Month in September include proclamation signing ceremonies with the Governor and county mayors, youth and adult sign-waving, vigils, and other community awareness events. A statewide Mental Health America Hawaii, Youth Leadership Council (YLC) for suicide prevention provides a youth voice for statewide suicide awareness and prevention work.

EMSIPSB Trauma System and the University of Hawaii, Department of Psychiatry are working with the Hawaii health care systems to develop prevention, awareness, early identification, access to effective treatment, enhanced discharge planning, and follow-up care coordination. Efforts to develop and promote effective clinical and professional practices and policies are aligned with Zero Suicide protocols.

3. Have you incorporated any strategies supportive of Zero Suicide? ☒ Yes ☐ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ☒ Yes ☐ No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? ☒ Yes ☐ No

If so, please describe the population targeted.

During the 2016 Hawaii State Legislative Session, a House Continuing Resolution (HCR66) was passed. The HCR calls for a

subcommittee of the statewide Prevent Suicide Hawaii Task Force (PSHTF) to develop a statewide strategic plan to reduce suicide in Hawaii 25% by 2025. The subcommittee was convened by the Emergency Medical Services and Injury Prevention System Branch (EMSIPSB) in June, 2016 and includes representatives from AMHD, CAMHD, the Department of Education, University of Hawaii, Veterans Administration, Army, Department of Public Safety, American Foundation for Suicide Prevention Hawaii, Mental Health America Hawaii, PSHTF members, and survivors of suicide. The plan will be completed by end of December 2017 and presented to the Legislature in January 2018.

Does the state have any activities related to this section that you would like to highlight?

The Adult Mental Health Division has contracted for the development of a suicide prevention app targeted for individuals in Hawaii who are at risk of attempting or completing suicide, at every age level, particularly youth and veterans.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

NOT FINAL

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ☒ Yes ☐ No
2. Has your state identified the need to develop new partnerships that you did not have in place? ☒ Yes ☐ No

If yes, with whom?

The Child and Adolescent Mental Health Division (CAMHD) developed new project in partnership with the Western Interstate Commission for Higher Education (WICHE) in 2017. CAMHD contracted with WICHE to conduct an assessment of CAMHD's Quality Improvement system, including standards, benchmarks, policies and procedures and measures. The study would also provide comparisons with other state systems in the domains of programmatic monitoring, clinical quality, billing compliance and customer and client service.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The State of Hawaii recognizes the importance of partnering with stakeholders to improve service delivery, cut costs, and advocate on behalf of consumers. As a result, the Adult Mental Health Division (AMHD) has partnered with several public and private stakeholders within the service population to implement proposed projects that impact state-operated community mental health centers, community health care providers, hospitals, and jails. These partnerships provide access to a wide array of evidence-based, patient-centered, trauma-informed care, housing and culturally-competent programs, services, and practices. Further, the AMHD's partnerships positively impact the community of persons with a serious mental illness through strengthened linkages through collaboration and coordination, developing and preserving affordable housing, increasing access to permanent supportive housing, maximizing federal, state and local funding, stimulating jobs and workforce development, and recognizing

veterans. Partners include: the Honolulu Police Department, Hospital Emergency Departments, the Judiciary Branch, the Developmental Disabilities Division, the Child and Adolescent Mental Health Division, the Vocational Rehabilitation Office, the Alcohol and Drug Abuse Division, the Executive Office on Aging, the Department of Human Services, and various Housing Coalitions.

In Hawaii, there's a shared community goal of placing a child in the least restrictive setting and avoiding inpatient hospitalizations whenever possible. This shared goal is a result of the Felix Consent Decree and the adoption of the CASSP Principles. With understanding, the Hawaii's youth-serving agencies in health, mental health, child welfare, education and judiciary work collaboratively on monitoring and evaluating the system's ability to maintain the shared goal. The key is to maintain a robust community-based system of care. With that, the use of hospitalizations is minimized.

The Hawaii Interagency State Youth Network of Care (HI-SYNC) collaboratively reports on performance outcomes on services for youth, including services provided by the school system. The collaborating organizations are:

Department of Health

- Child and Adolescent Mental health Division
- Family Health Services Division, Early Intervention Section
- Developmental Disabilities Division

Department of Education

- School-Based Behavioral Health
- Special Education

Department of Human Services

- Child Welfare Services

Hawaii State Judiciary

- Family Court

Each agency tracks its own performance measures on maintaining robust community-based services that meet the needs of youth. The annual reports, the Hawaii Youth Interagency Performance Report (HYIPR), highlight each agency's population, utilization, cost and performance outcomes. The Report is shared widely in the community to demonstrate transparency and accountability of the system of care in providing for Hawaii's vulnerable youth.

The CAMHD has a comprehensive system of monitoring the progress and effectiveness of community-based mental health services. CAMHD's Program Improvement and Communications Office analyzes data on service utilization, costs, and outcomes for youth. The primary sources of information is the Child and Adolescent Mental Health Management Information System (CAMHMIS), which supports registration of youth with CAMHD, authorization of services, electronic billing for services, and child status monitoring functions. The database also include data collected and retrieved from an Electronic Health Record system, and from independent databases maintained by various offices within CAMHD. CAMHD's Administrative Services Office maintains databases for manual billing information and contracts. The CAMHD Clinical Services Office maintains a database of youth placed in out-of-home settings based on weekly provider census reports, and the Performance Management Office maintains a database of sentinel events and reportable incidents based on reports submitted by providers. CAMHD develops an Annual Factbook which provides detailed reference information regarding the CAMHD population, services, and outcomes. CAMHD tracks multiple data over time (trends), including diagnosis, test scores at entry and discharge, age, gender, race, registration by location, length of stay, utilization by service, service settings and service formats, treatment targets, discharge information, sentinel events, and costs per youth. This information is shared with the community, our partners, and the public.

The University of Hawaii, Department of Psychology, brings its behavioral science evaluation, management information systems and clinical expertise to bear for CAMHD. The Psychology Department has the unique advantage of being an external partner with access to the internal clinical and data management processes at CAMHD. As such, it often provides key direction on how to improve clinical services and client outcomes. See the Letter of Support from the University of Hawaii in the Attachments for more detailed information.

Does the state have any activities related to this section that you would like to highlight?

None at this time.

Please indicate areas of technical assistance needed related to this section.

Footnotes:



August 10, 2017

Dr. Stanton Michels
Division Chief Administrator
Central Administration Offices
Child and Adolescent Mental Health Division
3627 Kilauea Avenue, Room 101
Honolulu, Hawai'i 96816

Dear Dr. Michels:

It is our sincere pleasure to write this letter of support for the Child and Adolescent Mental Health Division's (CAMHD) application for a block grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The work that you and the division you oversee has improved the lives of children and adolescents in Hawai'i immensely. We are particularly impressed and gratified by the way you have led the Division as it transforms into an efficient, outcome oriented, family centered system of care. Your development of strong business practices and use of modern information technology while retaining core CASSP principles puts CAMHD at the forefront of public mental health services. The funds from the block grant have enabled you and your team to develop, deliver and coordinate effective services. With the continuation of this grant, I have no doubt you will be able to improve the lives of many more youth and families.

As you know, we are faculty members of the Department of Psychology at the University of Hawai'i at Mānoa (UHM). We have worked with and advocated for children and adolescents in Hawai'i for over 45 years combined. We have directly worked with CAMHD for the last thirteen years and we look forward to continuing this productive and engaging relationship. Our work with CAMHD now includes research and evaluation support and training, supervision of information technology and report writing positions, clinical psychology workforce development, provision and supervision of assessment and treatment services, advancement of the use of evidence-based services throughout the system, and the development and implementation of a first episode clinic for young people with psychosis.

Over the last 12 years, we have coordinated the Research, Evaluation and Training Team (RET). RET is a behavioral science evaluation and service collaborative partnership between the Department of Psychology at the UHM and CAMHD, designed to provide leaders and leadership in child and adolescent mental health research and evaluation. The RET combines research and evaluation expertise from both state and UHM contracted staff and supports the CAMHD Research and Evaluation Office (REO). The primary purpose of REO is to provide leadership and management regarding the division's efforts to conduct comprehensive evaluation of CAMHD's system. The office works with CAMHD's other offices to develop and oversee empirically sound investigations of all aspects of the CAMHD system, while supporting the system's application of relevant research literature and evidence-based practices. REO also serves as a liaison to external researchers and evaluators and participates in the development, implementation, and monitoring of division-wide strategies and objectives.

Our work with CAMHD has extended into recruitment, hiring and administrative supervision of Research Corporation of University of Hawai'i (RCUH) personnel to support CAMHD information technology, management information and direct clinical services. Currently we have on board a Report Writing Specialist focused on developing and implementing programing that translates systems data into actionable information. One example of this is the development of single case and aggregated reports of treatment progress from routine CAMHD data collection. We also have hired a telehealth support specialist who is embedded in CAMHD's information technology team and facilitates appropriate use of data and technologies throughout the system. With your collaboration, we have found predictors of client success and have begun to develop procedures and technology to assure clients at risk of poor outcomes are identified early so that they too can succeed. These analytics are also helping CAMHD increase efficiencies and improve client-level of care matching. Through this collaboration, fourteen theses or dissertations have been completed at no or very little cost to CAMHD or UHM. More studies are underway. In all cases, findings from these studies are provided back to CAMHD and other stakeholders that can use such data in system-wide decision-making.

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In addition, we oversee the Child Program of the Center for Cognitive Behavior Therapy (C-CCBT), a research, training, and service clinic in the Department of Psychology at the UHM. C-CCBT contracts with both CAMHD and the State of Hawai'i's Department of Education to train Ph.D.-level psychology graduate students in evidence-based assessment and treatment strategies and to provide evidence-based consultation, assessment and intervention services. Together, we have developed and implemented tele-mental-health procedures that increase our efficiency in serving geographically isolated communities. C-CCBT has trained a multitude of graduate students and postdoctoral fellows, and has delivered services statewide to well over 2,500 youth over the past 20 years.

Dr. Nakamura co-leads CAMHD's Evidence-Based Services (EBS) Committee, an interdisciplinary workgroup composed of stakeholders from numerous practice, research, educational, and service-delivery settings. First established in 1999, the mission of the EBS committee is to provide relevant, easily understood, and up-to-date knowledge to key stakeholders in order to support evidence-based decision making and the CAMHD mission of timely and effective services for youth and their families. Current noteworthy initiatives of the EBS Committee include youth and family empowerment efforts, such as routinely updating CAMHD's consumer-oriented website (<http://helpyourkeiki.com>), as well as broader professional stakeholder outreach on a wide variety of youth evidence-based treatment approaches. The committee's major outreach and routine interface with the larger community on evidence-based treatment approaches has been its quarterly roundtable forum, which is now entering its fifth year for successfully highlighting a wide array of other CAMHD system supports.

Over the last few years we have supported Dr. David Cicero (now an Associate Professor in our Department) to adapt the Recovery After Initial Schizophrenia Episode (RAISE) Coordinated Specialty Care model to our local mental health care system in Hawai'i. We are now implementing our model (OnTrack Hawai'i) while gradually adding additional elements. This is a necessary program in Hawai'i, because there are currently no specialty programs for young people with psychosis anywhere else in the state. We have worked with CAMHD and other local organizations, including the University of Hawai'i's Department of Psychiatry, to ensure that the program is sustainable over the long-term in Hawai'i.

Just recently, four of our highly trained and most promising PhD clinical psychology students have accepted public mental health positions here in our state. Two of the positions are clinical with strong program development, quality assurance and supervision of evidence-based services. The other two position are more focused on systems evaluation and improvement. We are both proud and excited that our most promising doctoral graduates are committing to public child mental health leadership. Thank you for your support of these future leaders.

Children's mental health care in Hawai'i has dramatically advanced in the last 30 years but we still have a long way to go. We are extremely confident that CAMHD continues to push the system in positive directions and is leading our state in the development of a powerful and sustainable system of care. Thank you for all the work you and your team have done and all the accomplishment therewith. We are committed to doing everything we can, in partnership with CAMHD, to further your success. We look forward to continuing this productive collaboration for many years to come.

Sincerely,

Charles W. Mueller
Professor
Department of Psychology
University of Hawai'i at Mānoa
2530 Dole St. Sakamaki C-400
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COLLEGE OF SOCIAL SCIENCES
UNIVERSITY OF HAWAI'I AT MĀNOA

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Clinical Studies Program
Department of Psychology

NOT FINAL

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Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁷²

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

⁷²<http://beta.samhsa.gov/grants/block-grants/resources>

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

- a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The State Council on Mental Health, also known as the Planning Council, is a diverse group of individuals comprised of consumers of mental health services, family members, representatives from each of the four county Service Area Boards, representatives of state agencies, and other community stakeholders. The Council maintains a membership of twenty-one members, who are appointed by the Governor and confirmed by the Senate during Hawaii's Legislative Sessions. One member is in a dual role by participating in the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS). HACDACS minutes and legislative involvement are shared monthly with Council members. The Council operates under the following laws: Hawaii Administrative Rules, Hawaii Revised Statutes, Sunshine Law and Federal Law.

During its July 11, 2017 meeting, members selected an Ad Hoc Committee of Permitted Interaction Group of individuals to review the FFY2018-2019 Mental Health Block Grant Application in August. This committee plans on providing a full report to the larger Council, and provide feedback to the Adult Mental Health Division (AMHD) and the Child and Adolescent Mental Health Division (CAMHD).

The Council has invited the Chair and the Administrator of the Hawaii Advisory Commission on Drug Abuse and Controlled Substances to its meetings to discuss substance use legislation, latest programs in substance use disorders, the opioid epidemic, and the Commission's Strategic Plan. Similarly, the Administrators of both AMHD and CAMHD attend monthly State Council meetings to provide updates on mental health issues/services and activities of their respective divisions to the group.

- b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i ☒ Yes ☐ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ☒ Yes ☐ No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Hawaii's State Council on Mental Health, also known as the State Planning Council, is an active advocacy group providing a voice for children, youth, adults, and their families on behavioral health issues. The mission of the Council is to advocate for a Hawaii where all persons affected by mental illness can access treatment and support necessary to live a full life in the community of their choice.

As defined by state and federal statute, the purpose of the Council is:

- To serve as an advocate for adults diagnosed with a severe mental illness, for children and youth diagnosed with serious emotional disturbance;
- To advise the state mental health authority on issues of concern, policies and programs;
- To provide guidance to the state mental health authority on the development and implementation of the state mental health system's plans; and
- To monitor, review, and evaluate the allocations and adequacy of mental health services within the state on an ongoing basis.

The Council meets monthly to identify and discuss the needs of persons with mental health challenges. At each meeting, the Council allots time for community members to raise issues for the Council's consideration. A standing item on each month's agenda is the inclusion of reports from each of the regional Service Area Boards. The role of the Service Area Boards is to identify behavioral health-related issues in the community. The membership of the State Council and each of the Service Area Boards include consumers, family members, providers, community members, and state employees. These volunteers give their time, energy, expertise and experience to improve and advocate for a system of care that provides quality mental health services to the people of Hawaii. As part of the Council's consideration, the State Council often requests agencies and organizations to provide reports on their activities, outcomes and processes. This allows the Council an understanding of the wider system of care and may make recommendations how those supports could be improved to benefit persons with behavioral health challenges.

Based on the issues raised in those forums, the State Council has the responsibility to represent the interests of its constituency and advocate for change. The State Council has been active in policy development, often testifying before the Hawaii State Legislature on issues of concern. The Council also provides the Legislature an Annual Report summarizing their activities and outcomes for the year. As an advisory body to the Department of Health, the State Council annual reviews the SAMHSA Mental Health Block grant and provides its input.

Does the state have any activities related to this section that you would like to highlight?

During the 2017 Hawaii State Legislature, the State Council on Mental Health brought their considerable influence to bear on the following:

HB100HD1 - The State Council offered strong support for HB100, HD1 Relating to the State Budget. The Council advocated for an increase of Purchase of Service Providers contracted to provide services by the Child & Adolescent Mental Health Division. Their testimony requested \$1.4 million in FY2018 and \$1.6 million in FY2019 to meet the increased costs of providing mental health services to youth and families. The Council stated that the providers had not had an increase in the past 10 years, while the costs to provide the services increased. The Governor released the funds to the Child & Adolescent Mental Health Division.

HB554HD1 - The State Council provided strong support of HB554, HD1, Relating to Orders for Treatment Over Objection. The bill would establish a much needed administrative non-judicial panel to review and authorize Orders for Treatment Over Objection that are administered in a hospital setting. The Council pointed out that the Adult Mental Health Division data show that of the 57 instances where authorization to treat over objection was requested in 2016, the time between the filing of the petition and the judicial hearing was on average 16.8 days, with the longest period being 50 days. The Council provided the perspective of a consumer experiencing acute mental health symptoms such as active auditory, visual and sensory hallucinations, irrational thoughts and beliefs, paranoia and active self harm to self or others, waiting for 50 days for a judicial hearing to be convened. HB554 was passed and became law.

SB149 - The State Council submitted strong support for SB149 Relating to Procurement. In its testimony, the State Council pointed that existing procurement rules provide unnecessary barriers to establishing needed mental health services. In particular, Special Treatment Facilities that can provide specialized care in community-based settings for consumers who no longer need acute level hospitalization care, could be procured with the passage of the bill. SB149 became law.

Please indicate areas of technical assistance needed related to this section.

Technical assistance is not needed at this time.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷³

⁷³There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Shannessy Ahu	State Employees	Vocational Rehabilitation	1265 Alaamoamo Street Honolulu HI, 96819 PH: 808-741-2675	shannessy.hawaii@gmail.com
Kathryn Boyer	State Employees	Department of Human Services	810 Richards Street Honolulu HI, 96813 PH: 808-586-5698 FX: 808-586-4806	kboyer@dhs.hawaii.gov
Sheila Calcagno	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Kauai Service Area Board on Mental Health and Substance Abuse	P.O. Box 370 Kilauea HI, 96754 PH: 808-821-8167	sheilainhi@yahoo.com
Louise Crum	State Employees	Criminal Justice	Mental Health Court Honolulu HI, 96813 PH: 808-593-4573	louise.k.crum@courts.hawaii.gov
Cynthia Dang	Others (Not State employees or providers)	Oahu Service Area Board on Mental Health and Substance Abuse	P.O. Box 893012 Millilani HI, 96789 PH: 808-492-5818	leanpathways@gmail.com
Charlene Daraban	Family Members of Individuals in Recovery (to include family members of adults with SMI)		275 Olive Avenue Wahiawa HI, 96786 PH: 808-487-8785	charlenedaraban5@yahoo.com
Arwyn Jackson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1253 S. Beretania Street Honolulu HI, 96814 PH: 262-424-9795	arwynjackson@gmail.com
Ciara Kahahane	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1914 University Avenue Honolulu HI, 96822 PH: 808-283-0086	ciarakah@hawaii.edu
Chad Koyanagi, M.D.	State Employees	Department of Human Services - Med-QUEST Division	601 Kamokila Blvd., Room 415 Kapolei HI, 96707-2021 PH: 808-692-7364	ckoyanagi@medicaid.dhs.state.hi.us
Beatrice Martinez	State Employees	Hawaii Public Housing Authority	1002 N. School Street, Bldg. G Honolulu HI, 96817 PH: 808-832-4688	
Susan Pelowski	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Honolulu HI, 98013	
Jennifer Renfro	State Employees	Department of Education	91-1385 Kai Okia Ewa Beach HI, 96706 PH: 808-305-9789	jennifer_renfro@notes.k12.hi.us
			1511 Nuuanu	

Richard Ries, Psy.D. M.S. Ed.	Providers	University of Hawaii	Avenue Honolulu HI, 96817 PH: 808-295-3999	miko_ries@yahoo.com
Christopher Rocchio	Family Members of Individuals in Recovery (to include family members of adults with SMI)		2040 Nu'uanu Avenue Honolulu HI, 96817 PH: 808-679-9876	crocchio@hawaii.edu
Caprena Rowe	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2747 S. Kihei Rd., E- 202 Kihei HI, 96753 PH: 808-244-4193	anerpac40@gmail.com
Scott Shimabukuro, Ph.D.	State Employees	Child and Adolescent Mental Health Division	3627 Kilauea Avenue, Room 101 Honolulu HI, 96816 PH: 808-733-9333	scott.shimabukuro@doh.hawaii.gov
Sandra Simms, (Rtd. Judge)	Family Members of Individuals in Recovery (to include family members of adults with SMI)		94-415 Kealakaa Street Mililani HI, 96789 PH: 808-222-5501	sandra.simms48@gmail.com
Marie Vorsino, Psy.D.	Providers	Parents and Children Together	1505 Dillingham Blvd., Ste. 208 Honolulu HI, 96817 PH: 808-846-4079	mvorsino@pacthawaii.org

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	21	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	5	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	3	
Others (Not State employees or providers)	1	
Total Individuals in Recovery, Family Members & Others	12	57.14%
State Employees	7	
Providers	2	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	9	42.86%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Planning Council was given the opportunity to review the 2018-2019 Mental Health Block Grant Application and to provide feedback to the State Planners.

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
- | | | |
|----|--|---|
| a) | Public meetings or hearings? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| b) | Posting of the plan on the web for public comment? | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| c) | Other (e.g. public service announcements, print media) | <input type="radio"/> Yes <input checked="" type="radio"/> No |
- If yes, provide URL:

Footnotes:

NOT FINAL